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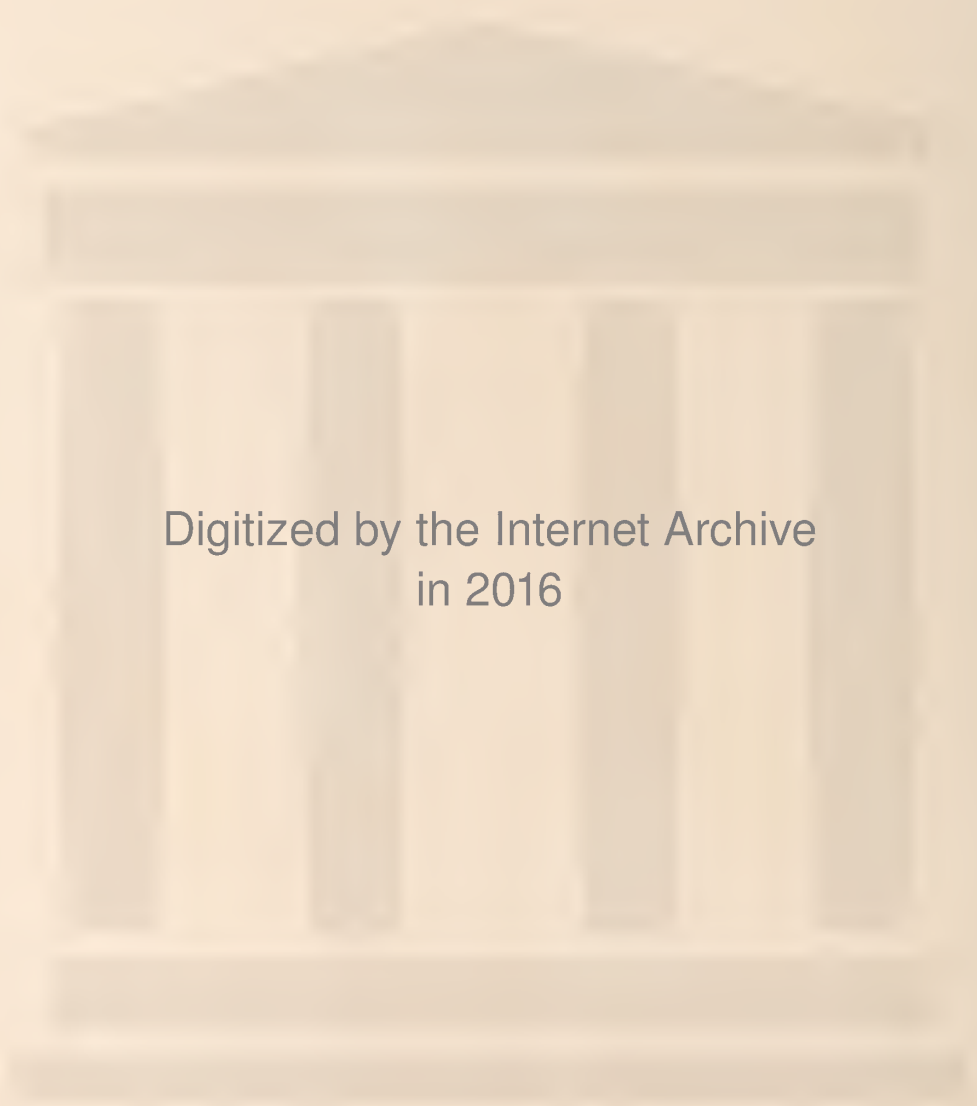
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The Journal

OF THE KENTUCKY STATE MEDICAL ASSOCIATION

VOL. 50

JANUARY, 1952

NO. 1

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The JOURNAL *of the* Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

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The Status of Total Gastrectomy in the Treatment of Gastric Cancer

COLEMAN C. JOHNSTON, M. D.

LEXINGTON

A solution to the tragic and disheartening problem of malignant disease of the stomach as yet has not become available to the medical profession and as a result there has developed an attitude of discouragement and defeatism which is quite generally accepted. All too frequently the surgeon of today will settle for what amounts virtually to palliation or at most the expenditure of less than an all out effort at radical extirpation. For this reason an evaluation of the status of total gastrectomy is being presented for consideration.

When we realize that in 1881, 70 years ago this 29th day of January, 1951, the great Billroth first successfully removed by partial gastrectomy a gelatinous carcinoma of the stomach from one Theresa Heller, it gives us pause to consider that perhaps some of us have made only small progress since that time. However, leaders in the field of gastric surgery have, with courage and conviction, increased the therapeutic horizon in the treatment of gastric cancer to include the more general use of the radical total gastrectomy, for after thoughtful consideration it must be observed that partial gastrectomy is a most inadequate approach to the problem.

Concept of Radical Extirpation

Halsted established the principle of radical extirpation for malignant disease of the breast with removal of adjacent lymphatics. Miles followed this concept in developing his generally accepted procedure for radical combined abdominoperineal extirpation of carcinoma of the rectum. It is, therefore, logical to suppose that the same thesis must be applied to the surgical treatment of cancer of the

stomach if an equal success is to be achieved. In many areas, however, the profession is slow to accept the use of total gastrectomy with block removal of adjacent gland-bearing tissues.

Summary of Progress Since Billroth

It was in 1883 that Conner of Cincinnati first conceived and performed a total gastrectomy, although his patient died. In 1897 Schlatter of Zurich, Switzerland, was the first to successfully perform the operation, and a year later Brigham of San Francisco reported the initial success with total gastrectomy in the United States. Interestingly enough he established continuity between the esophagus and the jejunum with a Murphy button. By 1905, Paterson in a review of the literature discovered that 27 patients had undergone total gastrectomy, 17 patients survived, an operative mortality of 37%; ten were living and well from one to eight years thereafter, while seven died of recurrence in from seven months to three years.

By 1929, Finney found that 62 total gastrectomies had been reported, adding five cases of his own. At this time the operative mortality was recorded as 53.8%.

In 1939, Lahey presented nine total gastrectomies with a 44% mortality.

In 1943, Horsley reported three successful total gastrectomies, although he courageously observed that they were preceded by the experience gained from a series of 12 failures.

By 1947, Ransom reported 53 total gastrectomies for carcinoma with a mortality of 22.3%.

In 1948, Kremer reported a 10% mortality in 48 total gastrectomies and later

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observed that since 1949, 15 of these operations had been performed with only one death. Longmire and Scott in 1949 reported 62 total gastrectomies, 55 for cancer, three for sarcoma, one for syphilis and three for benign ulcers thought to be malignant, with a mortality of 9.5%. Most of the last 33 operations were performed by the Resident Staff at the Hopkins Hospital and in this group only one death occurred, giving a mortality of 3.3%.

A most comprehensive presentation of the subject was made by Lahey and Marshall in 1950, when they reported a series of 139 total gastric resections from 1927 to 1950. In the first 75 patients operated prior to 1943, the mortality was 34.6%. From 1944 to 1950, 64 such operations were reported with a mortality of 9.4%. In short, vast strides have been made in the successful accomplishment of this procedure and there is slowly developing a more general trend toward its acceptance. Lahey has gone so far as to suggest that it might be wise to use total gastrectomy not only for the extensive lesions but also the smaller early malignancies of the stomach which are now usually removed by partial gastrectomy only.

Wagensteen, an advocate of radical extirpation, has gone so far as to adopt the policy of a "second look" in those patients in whom glandular involvement was found at the original resection. He has done a "second look" on two asymptomatic patients thus treated. One showed no evidence of recurrence, but in the second he removed two carcinomatous glands. This patient has already consented to a second "second look." Wagensteen feels that in the surgery of malignant disease, this type of repeated endeavor may well prove its worth.

Number of Cases and Mortality

Here then we have a brief summary of the progress that has been made since the time of Billroth. It is encouraging to note this more aggressive attitude which has manifested itself in the past two decades. For this reason, if for no other, it would seem a matter of vital importance to disseminate this information to the grass roots of our profession, in order to help dispel the shadow of gloom and discouragement which now prevails. There are none the less 40,000 deaths a year from carcinoma of the stomach in the U. S. and it is thought that there are nearly 40,000 new cases each year.

Total surgical extirpation of the stomach is a difficult and hazardous procedure, but the logic of its conception is sound and the mortality incident to its use is constantly being reduced to a more nearly respectable figure.

Pathological Survey

In a pathological survey of gastric carcinoma the lesion may range from the localized papillomatous tumor to the extensive infiltrating or leather-bottle type of diffuse cancer involving the entire stomach. All gradients and variations may occur and only by actual serial section and microscopic study can the limitations of the process be determined. The rich network of lymphatics and small blood vessels that course through the mucosal, submucosal and muscular layers of the stomach present a fertile field for malignant extension. In addition to the extension visible to the naked eye, or noted on palpation, there may be an invisible and imperceptible spread, not only throughout all the layers of the stomach wall itself but by continuity downward into the proximal duodenum, or upward into the lower esophagus, as well as to adjacent lymphatics. Even in direct attachment to adjacent viscera or parietes it is often impossible to determine if this adherence is still inflammatory or has become the inevitable malignant infiltration. Collier, Key and McIntyre, in studying the extent of malignant invasion in 53 cases of gastric cancer, noted that the duodenum was involved in 26.4% of these patients. Castleman reported 21 cases in which the duodenum had been invaded for a distance of from four to 23 mm. beyond the pylorus. Atkins of Guys Hospital, London, demonstrated microscopically carcinoma cells at the proximal margins of 18 out of 19 specimens of cancer of the stomach removed by subtotal gastrectomy. Warren's autopsy studies of 122 patients who succumbed to recurrence after partial gastrectomy revealed cancer in the gastric stump in 23 patients. Here again then, it is obvious that gross examination and palpation of the stomach itself are futile gestures in determining the extent of involvement. The presence or absence of glandular involvement has a direct bearing on the prognosis of gastric malignancy as it does on the prognosis of malignant disease elsewhere in the body. Of course, if total gastrectomy is reserved only for the advanced lesions ob-

viously inoperable by less radical standards, glandular involvement will of necessity be high. Collier reports a figure of 75%, the Lahey Clinic 65.4%, while the Hopkins group observed 62% in the limited growths and 80% glandular involvement in the infiltrating lesions. Moore observed that of 100 patients surviving resection for gastric cancer, those without glandular involvement alive after three years were four times the number of survivals with glandular metastases. The resectability rate in large series of gastric cancer has in the past been recorded as about 25%, but more recent studies showed a marked increase. Pack and McNeer report a figure of 48.1, while Longmire and Scott, in reviewing 144 patients with cancer of the stomach, resected 91 or 63% of the group. Although the five year survival rate up until recently had attained the height of only around 22% of resected cases, it is logical to suppose that with an increasing resectability rate and a more wide-spread use of total gastrectomy even in the earlier lesions, our five year survival figures should show a marked improvement as a culmination of this concerted effort to combat gastric malignancy.

To avoid the risk of tiring the average reader with technical details easily available to those interested, the technique of total gastrectomy will not be discussed. Suffice it to say that the procedure is a long and difficult operation requiring expert anesthesia, a very careful preoperative preparation and extremely conscientious postoperative management.

Morbidity

There has been much discussion as to the morbidity of total gastrectomy and for years the problem of the post-gastrectomy anemia has been unduly emphasized. In reviewing the literature it would seem proper to conclude that in the main this exaggerated morbidity and the associated bad results so glibly discussed must in part be attributed to the presence of unrecognized slow growing residua of cancer, developing gradually into lethal recurrences. It is interesting to note that patients surviving four years rarely succumb to recurrence.

Physiological Adjustment

It has been observed by most that in general a fairly satisfactory physiological

adjustment is made by the majority of patients following total gastrectomy, who do not develop a recurrence of the disease. Farris, Ransom and Collier in 1943, after a study of 23 gastrectomized patients, commented that it was surprising how little their lives had been changed. Most patients gain weight, though few attain their preoperative status. The food capacity is at first limited but gradually increases and often reaches very satisfactory proportions. Appetite and bowel habits are usually quite normal. Rarely a transitory diarrhea may develop, but it is of no serious import. The dumping syndrome is occasionally noted but tends to subside after about six months. Substernal distress, or burning if present, results from the regurgitation of biliary and pancreatic secretions but can be controlled with Amphogel and is usually prevented by entero-enterostomy done at the time of the original procedure. Dysphagia is uncommon but may develop as a result of partial closure of the esophago-jejunal stoma from stricture. Dilatation is, therefore, indicated but must be done with care and the use of the string bougie guide is definitely contraindicated as it may become entwined about the enterostomy. A fatal result from this accident has been reported. In the series of 139 cases reported from the Lahey Clinic, 42 patients required dilatation at one time or another in their postoperative course. The possibility of recurrence at the site of the anastomosis must be considered, but esophagoscopy and biopsy may be used to establish the differential diagnosis before dilatation is begun.

Hematologic Changes

Hematologic changes do occur after total gastrectomy and for this reason interval studies are imperative. Usually the initial change is that of a hypochromic anemia due to an iron deficiency. This type of anemia usually develops from one to three years after operation and is readily controlled with the usual therapeutic doses of ferrous iron given one week of each month, or by giving dilute HCl with meals. Foods rich in iron contain the ferric salt which is not absorbed in the intestine. It may, however, be easily converted to the readily assimilated ferrous salt by the simple expedient of adding dilute HCl.

Usually somewhat later in the postoperative course a macrocytic megaloblastic

type of anemia may develop, but this can be quite satisfactorily treated with liver extract or B-12 preparations. Occasionally the two types of anemia may occur simultaneously or in rapid sequence but adequate laboratory studies will serve to reveal their presence and guide in their management.

Early in the postoperative course it is wise to follow a daily diet of six small meals of bland soft foods high in protein content. Vitamins and ferrous iron form a worthwhile supplement. With time three of the meals are gradually increased in size and the interval feedings are slowly decreased and eventually discontinued.

In those patients with adequate teeth or dentures, careful chewing of foods is important, otherwise it is well to advise ground meats and pureed foods. Should the dumping syndrome present, the increase in solid foods with a minimal use of fluids and the elimination of all cold liquids will usually relieve the symptoms. Reclining immediately after meals is often helpful in minimizing the discomfort.

Value of Early Diagnosis

Perhaps the greatest single drawback to our successful treatment of gastric cancer is the fact that an early diagnosis is very difficult to establish. In the 10,890 patients seen at the Mayo Clinic from 1907 to 1938 with a diagnosis of cancer of the stomach, 42.7% were considered inoperable, 22.3% were explored and closed, nine and one-half per cent were subjected to some palliative procedure, but only 25.5% were resected with the hope of cure. Although these figures might not apply today in the larger clinics, they represent pretty well the run of mine medical and surgical practice of the average community. It is, therefore, imperative that some improvement be made in order that these patients present themselves for earlier surgical treatment.

Diagnostic Salient Features

First, the public must be educated to the point where they will seek consultation for vague upper gastro-intestinal symptoms.

Second, the medical profession must be taught to appreciate the really great possibility of cure in early gastric cancer.

Third, the roentgenologist must be freely and repeatedly consulted at appropriate intervals in the face of persistent upper gastro-intestinal symptoms.

Fourth, the gastroscopist should be consulted in the presence of any questionable x-ray findings, or in the absence of x-ray evidence of pathology if symptoms persist.

Fifth, all gastric ulcers should be resected or followed at short intervals by gastroscopy until long after the ulcer has healed.

All patients with pernicious anemia should be followed with interval x-ray and gastroscopy studies, because atrophic gastritis invariably follows pernicious anemia and in the atrophic mucosa the incidence of cancer is far higher than in the normal gastric mucosa.

Conclusions

1. In conclusion a brief review of the literature on total gastrectomy for the treatment of carcinoma of the stomach has been presented.

2. This study is heartening because it reveals the development of a more aggressive attitude among surgeons interested in the problem, as evidenced by the ever increasing number of successful reports of patients being treated with total gastrectomy.

3. Accumulated experience with this radical operation has increased the operability rate to between 48 to 63%, while the more respectable operative mortality of 10% or below has been achieved in several large series. These steadily improving figures suggest the inevitable rise in the five year survival rate now quoted as about 22% of those resected.

4. It has been observed that 40,000 persons die each year in the U. S. from cancer of the stomach and that 40,000 new cases develop annually, hence an earlier diagnosis is our greatest source of potential help in improving the end results in the treatment of gastric cancer.

5. The earlier diagnosis of gastric carcinoma can be established by educating the public, as well as the profession, to heed vague, mild upper gastro-intestinal symptoms. To consult the roentgenologist and the gastroscopist when indicated and to submit to exploration when in doubt as to the presence of an early gastric carcinoma.

6. It has been pointed out that the operation of partial gastrectomy does not fulfill the principles of radical surgery for malignant disease and is, therefore, not only an incomplete but obviously an illogical operation for the treatment of gastric cancer except in early minimal lesions.

7. It has been further suggested that if

only total gastrectomy is justified in the face of advanced disease with slight chance of cure, why then should it not be the surgeon's obligation to use total gastrectomy in the less advanced malignant lesions of the stomach with a far better chance of ultimate cure.

The Eye, the Patient, and the Physician

W. LLOYD ADAMS, Ph.D., M. D.

LEXINGTON

Preventive medicine in Ophthalmology pays big dividends in better eyesight and happier lives. Relatively little effort has been expended in this field compared to the need which exists. As in any branch of medicine, education of the patient is a legitimate means to secure the preventive aspects sought. An intelligent patient can grasp more than the less intelligent, but unfortunately the family physician, the internist or the oculist has comparatively little time to devote to the education of the individual. This lack of time makes it more imperative that certain considerations be kept in mind in order to be of greater service to the patient.

A view of some of the aspects of Ophthalmology or ophthalmologic practice which may give insight to the busy physician and help him in advising his patient should be of value. This forms the content of this discussion. It is surprising to note how many patients are grossly ignorant or neglectful of simple facts which could help to make for better vision. At times even a few simple words will dispel needless anxiety; at other times they may avoid misconceptions and practices which are directly detrimental to the welfare of the patient's eyes.

Various Cults Discussed

Only the rare patient can satisfactorily differentiate the ophthalmologist or oculist, the optometrist and the optician. Most patients do not know that only the oculist is a physician who is trained to give the eye the complete examination which would recognize existing or impending disease, and that only he is trained in the use of drugs and, therefore, the only one

permitted by law to use what is commonly known as "drops" in the eyes. No ocular procedure is more feared by a few patients than the use of "drops" or cycloplegic drugs. Some regard their use with as much apprehension as a surgical procedure until they have once experienced their use. Others, of course, are mindful only of the temporary disability for near work, the light glare, or the occasionally ensuing headache. This aversion is capitalized on by such misleading advertising as was heard on a recent local radio program. An optometrist invited the public to come in and have the eyes refracted "the modern, convenient way without drops." The public, of course, is largely unaware that such practice is neither modern, nor fair to the patient in many cases, especially where children or presbyopic individuals are concerned, and that the advertiser is prohibited from using the drops when they are indicated. Patients should be educated to know that "drops" are usually painless, that they put the intrinsic muscles of the eyes at rest, that the dilatation of the pupil permits a more thorough ophthalmoscopic examination, that they may help to discover early disease (e. g. glaucoma), that glare is easily controlled, and that there are means of shortening the time of pupillary dilatation (by miotics).

Eyes of the Child

The importance of the period from birth to about the sixth year of life with reference to the eyes cannot be over-emphasized. The average parent thinks little of the functioning of the infant's eyes, unless attention is directed to the eye by some dramatic incident such as squint. Even when squint is present it is sometimes unwisely disregarded as something which

the child "will grow out of." Others believe that since the preschool child cannot co-operate because he cannot read, there is no way to ascertain whether or not vision is good. They are surprised to know that retinoscopic refraction can be practiced on the very youngest children. Parents are inadequately educated unless they understand that during the first two or three years of life, when visual acuity and reflexes are being perfected in a plastic neural system, the lifetime efficiency of the eyes is being determined. Too frequently the oculist encounters the poor vision of disuse called "amblyopia ex anopsia," when school experience after the age of six first brings the condition to light. It is then necessary to tell the saddened parents that the child should already have been under treatment about two or three years, and that it may now be too late for complete cure. It is probably impractical to expect all children to undergo examination during infancy, but to a high number of individuals, an examination during the second or third year of life would repay high dividends in better eyesight during the whole lifetime ahead.

Deficiencies of Eye Charts

Visual acuity is often the sole test of eye function in schools, factories or other places of general examination. The test is usually delegated to an untrained individual, and while it is perhaps the most expedient test to perform, it has its deficiencies. Unless a few standard precautions are observed in such testing, a recorded 20/20 may actually be anywhere from 20/15 to 20/50. The person being tested should not be permitted to see the chart binocularly before the individual eye is tested, and he should not be permitted to squint the eye to obtain better vision. Obviously, the testing is not unbiased if several persons in a group are tested within earshot of each other while the acuity chart is being read aloud. Defects of muscle balance, fusion ability and many other important factors may be unrecognized by both patient and examiner during the usual acuity test.

Value of Correct Examinations

Frequently a patient is found who boasts of his keen eyesight, although this is more often a personal opinion rather than the results of objective examination. It may be found that he does indeed have excellent vision in each eye; on the other

hand, his vision may be as low as 20/40 or 20/50, or one eye may be 20/15 while the other has far less acuity without the patient having been aware of it. The myope, or near-sighted person, who has never been fully corrected for far vision and has thus lived in a circumscribed world, does not realize what normal vision is, and often is amazed at the world about him when adequate correction of his refractive error is made. There is also the type of patient who has gradually acquired a small degree of astigmatism but has never had to wear glasses. On reaching presbyopia the need for help in near vision brings him to the oculist and the correction of his astigmatism gives him a clarity of far vision which is a revelation to him. Conversely, there is the patient who recognizes a decrease in his formerly excellent visual acuity and thinks only of the worst causes, such as cataract, for the impairment, when all he needs is a pair of glasses to restore his former efficiency.

Factors Producing Visual Comfort

The factors which tend to produce comfort in vision are many. Proper position of the reader and reading material is important. Such practices as slouching, reading while reclining, and holding reading matter at an improper angle, may not exact their toll for years, but when visual trouble is present these should be considered. Good illumination, or proper lighting for any specific use of the eyes is very important. For best results and eye comfort, general illumination of the environment should be so good that only a small amount of supplemental light should be necessary from a nearby light source. Thus, the typical student who sits in the darkened room with only the bright reading lamp at his desk, is subjecting his eyes to unnecessary strain.

Correction of Refractive Errors

Correction of refractive errors is, of course, most essential to visual comfort. Certain patients are surprised to learn that glasses do not signify weak eyes, and that myopia, hypermetropia (far-sightedness), and astigmatism are not diseases, but rather are manifestations of a physical variation in the eyes about a mean, or average, just as the heights and weights of individuals are variations about an average. To some patients it must be emphasized that the use of glasses will not, per se, weaken the eyes and make them less

able to function without glasses. Mothers are sometimes opposed to correction of their myopic children fearing that the myopia will increase because glasses are worn. Among the more difficult things for a few people to understand is that sometimes it is better for the eyes to wear glasses although the visual acuity may not be improved and occasionally may be slightly decreased. Thus, in some cases, comfort is obtained by correction of presbyopia, heterophoria (tendency to squint), or glare, in which the visual acuity may not be improved.

Better Acuity Sought

The objective of better acuity is always sought, but there are other considerations which may outweigh its importance. The objective may be the relief of a blepharitis, or inflammation of the lids, caused by passive congestion of the lid margins. This passive congestion is due in turn to contraction of the orbicularis oculi muscles as the eyes seek better vision by squinting. It is necessary, also, to remember that rigid glasses are, at best, a poor substitute for the normal flexible eye. In presbyopia, as the need for help in near work is met by increasing lens strength, the field of vision through the near segment is cut down (the amount of the page seen at one time is decreased) and the range of vision (distance from the eyes that the reading matter may be held) is decreased. The oculist is occasionally taxed to explain why the new lenses do not permit vision for fine print or work close at hand and also at arm's length, as former glasses did. The replacement of the flexibility of the natural lens of the eye with the rigidity of the glass lens is the explanation, yet this is incomprehensible to many. To some, any attempt to explain is viewed as an alibi for a deficiency in the prescription which was given.

Eyes of the Aged

Diseases and conditions of the eyes that attend advancing age often cause needless worry and apprehension. It is a distinct satisfaction to be able to reassure the patient who is worrying about the "cataract" "growing over" his eye, with the explanation that he has a relatively innocuous pterygium or a pinguecula. The disconcerting element here is the realization that the majority of the public labors under the impression that a cataract is a "growth" which gradually grows over or

in the eye to occlude sight, and that the cataract should be regarded with the same apprehension as cancer.

Constant good vision is notoriously hard to obtain in certain diabetics, hypertensives and alcoholics. These should be stabilized as well as possible before refractive correction is made. Both the patient and the physician should be aware that the refractive correction which is eminently satisfactory at one time may be unsatisfactory during fluctuations about the individual's homeostatic level. Cataract and irregular astigmatism are other common sources of failure to obtain satisfaction with glasses. Duke-Elder's admonition that if "the warning of overwork as manifested in the eyes is neglected, the glasses may provide the patient with the means wherewith to struggle on until he suffers a much more serious breakdown" should also be kept in mind when considering the patient with asthenopia.

Disease or Trauma

Aside from all that has been said, there are several considerations which may profitably be brought to attention here with respect to disease or trauma of the eye: (1) If adequate examination of the eye cannot be made in general practice, it is unwise to prescribe a local anesthetic for the eye unless the patient is told the nature of the prescription and cautioned not to fail to see the oculist as soon as possible. Also he should be advised not to use it in future eye trouble, and to discard the prescription after its use. Serious results have been produced by alleviating eye pain without insuring that the cause of the pain is properly diagnosed and treated. (2) In disease or trauma of the eye it is better not to instill atropine before referring the patient to the oculist. Homatropine temporarily will serve the purpose adequately if a cycloplegic is judged necessary, and the effect will not be so prolonged or dangerous if the oculist decides that mydriasis or cycloplegia is contraindicated. The cycloplegia induced by homatropine can be counteracted by pharmacological antagonists while that of atropine is largely refractory to such agents. Thus, if atropine were used in a case of glaucoma mistakenly diagnosed as iritis, the consequences might be quite serious. In trauma to the eye, where there is any doubt, the sooner the oculist can see the patient, the more likely is he able

to make a good examination.

In this short discussion an attempt has been made to enlist the aid of the oculists' colleagues in presenting a proper understanding of the eyes to their patients insofar as they have the time and the occasion. A few of the more commonly encountered misconceptions and areas of

difficulty which the patient has with regard to the eyes are mentioned. As life expectancy increases, the importance of conservation of eyesight increases, and the urgency for more preventive measures to insure good vision becomes more pressing.

Current Concepts in the Management of Chronic Pelvic Inflammatory Disease with Review of the Literature

GEORGE G. GREENE, M. D.

LEXINGTON

Since the advent of the sulfonamides and antibiotics Chronic Pelvic Inflammatory Disease has been greatly reduced. This disease robbed the women of our day of many useful and healthy happy hours, not to mention the pelvic discomfort suffered by those so afflicted. Although the chronic stage of this condition has been considerably eliminated by the above mentioned drugs, it still continues to take its toll of woman power hours and brings about a degree of invalidism that we would like to overcome.

It is a disease principally confined to the daily laboring group of women as this group is more frequently afflicted due to the known higher incidence among the less intellectual and poorer classes. Further elaboration on this phase of the subject I feel sure is unnecessary.

Review of the Treatment

Aside from prophylaxis which demands the number one spot on this subject I wish to focus on treatment of this disease and to confine this to the chronic stages of the disease, as it is with this form that we find our ingenuity over taxed and the therapeutic armamentarium completely exhausted time and again.

I have reviewed the literature extensively on this subject and it appears that less and less is being written on the matter. This is probably due to our superior treatment of today in the acute phase and the satisfactory results obtained thereby, thus reducing the need for so much discussion as was necessary fifteen to twenty years ago. Another reason no doubt which plays an important part is the fail-

ure of the profession to produce any one or two things of any importance in recent years.

I thought that it would be of interest to discuss this subject in relationship to advances in treatment in recent years. Therefore, I have divided the subject of treatment into three periods, namely: 1. Treatment prior to the sulfonamides, 2. Treatment since the introduction of the sulfonamides and, 3. Treatment since the introduction of the antibiotics. I will not try to subdivide the management of this condition into specific treatment of the organism concerned as this is most often not determined in the chronic stage and would be too voluminous for the time allowed for the discussion of this subject. Rather we will try to think of them collectively except in certain instances where specific reference may be made in order to clarify a particular point.

Treatment Prior to the Sulfonamides

Probably the oldest treatment in Chronic Pelvic Inflammatory Disease is that of heat. This still shares a prominent role. However, Roblee and Royston¹ discussing this treatment in 1932 concluded that this did not produce cures where cervical pathology is present as is usually the case. They recommended surgical heat (electrocoagulation) as a means of destroying the nidus of the organisms which have the opportunity of reinfecting the patient time and again if not destroyed by some means. This of course, cannot be obtained by medical heat alone. Ninety per cent had associated cellulitis. They claimed improvement in seventy-three per cent. This form of treatment is still recognized as a good one today.

Read at the January, 1951 meeting of the Louisville Obstetrical and Gynecological Society.

It is amusing to review an abstract from Aschners² article from Munich in 1929 in which he claims that surgery was avoided in all of his cases by placing five to ten leeches over the lower abdominal wall, giving calomel two to three times daily and lastly, by having the patient insert a suppository each day containing ichthyol and antipyrin. In cases tending to abscess formation globules were inserted containing certain gurs.

Aldridge³ in 1933 insisted on conservatism in treating Chronic Pelvic Inflammatory Disease. He presented 1021 cases observed and treated by him. He stated that it was generally conceded that seventy-five per cent of all pelvic inflammatory diseases was gonorrheal in origin and that in 72.2% of his cases the causative organism could not be determined. Even with his plea for conservative management, 113 patients came to surgery. His criteria for surgery was persistent symptoms and adnexal pathology plus those who had recurrent attacks of pain and disability.

Fifteen years ago Titus⁴ was much impressed by diathermy. He reported from the progress notes of 173 cases and stated that 61 of these did not have any pelvic pathology, and that 116 were so improved as to be discharged from the clinic. Quoting as follows, he stated that diathermy seems to do in weeks what it takes nature years to accomplish.

In 1936, Jacoby⁵ reported ten cases treated by iontophoresis of mecholyl by introducing the drug through the vaginal vault. He claimed seven were completely cured who had extensive pelvic inflammation. He concluded that this drug was superior to other methods of exciting pelvic hyperemia as it was more physiologic. Later the same author reported on fifty cases and still was very enthusiastic about this form of treatment.

Darling⁶ and others claimed 80% cures where three or more high temperature treatments were administered providing a body temperature of 106 to 107°. Adair also had praise for heat therapy. He claimed the Elliott treatment to be of value for local hyperthermia and also recommended the dry heat as well. He stated that in 300 cases there had been 90% subjective cures. About this same time (1938) the Ketterine Fever Cabinet was very popular. However, such men as Sage of Omaha and Kuhn of Oklahoma

City showed considerable lack of enthusiasm about this method of treatment.

Treatment of Pelvic Inflammatory Disease After the Advent of Sulfonamides

In 1941, several years after the introduction of sulfanilimide, Stone⁷ of New York, reported on the use of Testosterone Propionate. He reported six cases of pelvic inflammatory disease which he had been able to follow and all of these had previous masses prior to treatment. In five of the six cases, he reported a diminution in size of the pelvic mass, and in one case, claimed that the pelvic mass completely disappeared. His treatment was that of huge doses of testosterone, giving as much as 60 mgm per month. By using this large dose, he stated that he was able to suppress menstruation and he felt that it was through the suppression of the menstrual period that improvement could be expected. There are not many of us who subscribe to this form of treatment and especially so in unusually large doses, due to the undesirable side effects.

With the advent of sulfonamides, little use has been found for these drugs in the chronic stages of pelvic inflammatory disease.

On a large series of patients which were marked by Hyman Strauss et al⁸, as chronic gonorrheal patients, proven by previous culture studies, the line of treatment which they used was a one-day sulfonamide treatment. They used large doses of sulfadiazine and sulfathiazole, the usual dose being 6 to 8 grams per day. In this group, they claimed a disappearance of the gonococcus organism in 86 to 90%. They found a racial difference in response to the drugs used, failures being three to four times greater in the white race. Even with this high percentage cure, they concluded that the one-day treatment was not practicable and should be used only in cases where the time element is at a premium.

I do not believe that any of the present day thoughts along this line of treatment in any way compare with the results reported by these authors. This report was given in 1944, and of course, there have been many changes in the treatment since that time.

Douglas and associates⁹, reporting on treatment of gonorrhea in the female in 1942, concluded that sulfathiazole and sulfadiazine were the drugs of choice for

acute infections, but that there was no place for these drugs in the chronic pelvic infections.

During this same year, Dr. H. E. Miller¹⁰ reported on a large series of patients, followed by his brother, the late Dr. C. J. Miller, at the Charity Hospital, New Orleans, Louisiana. This was probably one of the largest series that has ever been reported. The first study dealt with a series of 6,184 cases. This is compared with a more recent study of 3,072 cases of salpingitis and allied conditions treated over a three year period. Dr. Miller goes into considerable detail regarding the surgical aspect of this condition. He concluded that chemotherapy is disappointing in infections above the external cervical os, but is a useful adjunct measured in properly selected cases. He stated that surgery is ultimately necessary in a large portion of cases of recurrent salpingitis, particularly in public institutions with a large number of Negro patients.

In the surgical cases, he showed a marked improvement in the mortality as compared with previous years. In the first group reported, the mortality was 2.5% as compared with the mortality of slightly less than 1% in a more recent study. He does not give chemotherapy any credit for this improvement but many other factors and stated that he felt that the basic reason was the institution of a resident system in the hospital.

It was interesting to note that Dr. Frederick Falls, Chicago¹¹, was placing great emphasis on treatment of pelvic inflammatory disease with a new machine called the Newman Thermo Flo. This appeared to be very much on the order of the Elliott Treatment, described many years before. His study appeared in 1942, a number of years after the introduction of sulfanilamide. This report dealt with 200 patients. Of this group, 141 or 70.5% supposedly were completely cured or had a marked improvement, while only 15 or 7.5% obtained only slight or no improvement. He recommended this therapy as both a pre and post-operative measure.

Some men, such as Krieg and collaborators¹², continue to be enthused over intradermal injections of bacterial vaccines and intra-muscular foreign proteins like sterile milk, etc. These have not maintained the interest of most men in the field of gynecology in the more recent years.

Treatment Since the Introduction of Anti-Biotics

Sicard and Arbid¹³ reported on twelve cases of pelvic infection treated by local injections of penicillin in 1947. In this group, there were seven cases of pelvic peritonitis and five cases of pyo-salpinx. They concluded that in cases of chronic salpingitis, without abscess formation, local injections of penicillin gave much better results. In five cases, where pyo-salpinx existed, better results were obtained with local injections of penicillin into the lateral cul-de-sac. None of their patients required subsequent medical treatment.

Dr. Harvey Matthews¹⁴, reviewing this article, did not believe that introduction of penicillin into a pelvic abscess, in any amount, could possibly have much effect in eliminating a bacterial infection. His opinion was that the repeated evacuation of the pus cured the patient and not the penicillin. He concludes that in chronic pelvic inflammatory disease, little or no value, irrespective of the method of administration, can be expected from the use of penicillin.

Due to the time element, I do not wish to discuss all of the different articles that have been written on penicillin therapy in chronic pelvic inflammatory disease, as I believe very much the same as Dr. Matthews. However, I do want to review briefly some of the other anti-biotics which I believe to be of little value, if any, in treatment of chronic pelvic inflammatory disease.

There are some cases where all treatment has failed, including penicillin, and in these cases, some of the newer anti-biotics such as chloromycetin seem to have given a more satisfactory response.

Altmeier¹⁵, reporting in S. G. & O. in 1950, illustrates a colored female who had become resistant to penicillin and chloromycetin in combination. However, when the treatment was reduced to a low dosage of chloromycetin alone, the response was quite satisfactory and the resolution of the infection occurred gradually. This patient had been diagnosed as having recurrent pelvic inflammatory disease.

In mixed infection, chloromycetin appears to be superior to penicillin, streptomycin or sulfadiazine.

Stevenson and Kohler¹⁶, reported on nine cases of pelvic infections. Four of

these had pelvic abscesses, which could be aspirated through the vaginal vault. Four were post-abortion sepsis and the other was a puerperal sepsis. Mixed infections were found in nearly all cases. Three of the four cases of pelvic cellulitis and abscess responded to chloromycetin promptly. Two of them had not been benefited by penicillin and sulfadiazine.

Wakeman and Lechevalier¹⁷, reporting in the *Journal of Science*, maintain that neomycin is distinct and separate from streptomycin or streptothricin. It is particularly active against streptomycin resistant bacteria and possesses considerably more activity against the bacillus of tuberculosis; therefore, they recommended it in patients with streptomycin resistant organisms or in mycobacterium tuberculosis.

Another drug which does not belong to the anti-biotics but has drawn considerable attention more recently is that of Jacobson's solution. This drug is a 4.1% solution of benzyl cinnamate ester in olive oil. This is not an entirely new drug and when first introduced in 1929 by Dr. Jacobson, it was used for the treatment of chronic middle ear inflammatory disease. In 1950, Drs. Vick and Markowitz¹⁸, reported on 55 cases treated with this solution. They attempted to choose patients that had not responded to the usual methods of therapy, such as sulfathiazole, penicillin, diathermy, douches and surgery. After the diagnosis of recurrent pelvic inflammatory disease, the solution was administered in 1 c.c. amounts three times a week for a total of eight injections. This routine was varied at times, increasing the number of injections and giving them more often. No apparent evidence of drug sensitivity or toxicity were noted in this series.

Objective improvement was graded as good in 66% of the patients, fair in 21%, and little or no improvement in 13%. Subjective improvement was graded as 49%, 36% and 15% respectively.

In comparing these patients which were treated with the more conventional forms of therapy, the authors observed that there was less recurrence when Jacobson's solution was used.

Surgical Aspect of Chronic Pelvic Inflammatory Disease

In 1917, Curtis¹⁹ roughly estimated that fifty per cent of all patients with salpingitis progressed to asymptomatic recovery.

One half of the remaining fifty per cent yielded to different forms of treatment well enough not to necessitate surgical interference. However, he stated that that leaves twenty-five per cent of these patients who will eventually require surgery. He stressed conservatism just as it is stressed today by practically every man in the field of gynecology.

It is interesting to note that with the lapse of thirty-three years, our treatment has not greatly improved in the way of preventive surgery and that still today, we are operating approximately fifteen per cent, even though we have all the present day wonder drugs at our disposal.

Four years later, Curtis was reporting his exhaustive study of the viability of gonococcus in the tubal wall and lumen. His conclusions were as follows:

"It has almost never been possible to obtain gonococci from culture from thoroughly ground Fallopian tubes removed from patients who have been free from fever and leucocytosis, for a period of more than ten days or two weeks. The Fallopian tube appears, therefore, not to be a focus for chronic gonorrheal infection.

Persistently active gonorrhea of the tubes is evidently ascribed either to recurrence from without or repeated invasion of the bacteria from the chronically infected lower genital tract."

This opinion prevailed for many years.

However, in 1938, Studdiford²⁰ studied this same problem and his conclusions were quite the opposite from those of Curtis. In studying 4 patients with gonococcus salpingitis, he found active foci of gonococcal infections for long periods of time and regarded many of the cases reported as acute exacerbations of chronic salpingitis being due to activation of residual infection rather than reinfection.

Hundley²¹ and his associates have recently been studying this problem, and of ten patients with chronic salpingitis, six of these revealed tubal infection who had longstanding chronic disease. This also suggests the postulate of Studdiford as being in all probability correct.

I believe it is worth mentioning that Mohler²⁵ in discussing pelvic inflammatory disease recently, brought out a point which no doubt will be a controversial one. He indicated that pelvic inflamma-

tion may be caused by changes in the status of pre-existing tumors and structures in the pelvis or physical changes in the structures of the pelvis and not be of infectious origin. Very few of us have ever given consideration to any other cause other than infection.

Dr. Harvey Matthews, in discussing this paper, readily disagreed with this idea, as will many others, I feel sure. However, the study gives us something more to think about and if it proves to be a fact, we can see how little we rightfully can expect from any of the anti-biotics or sulfonamides.

Indications for Operation

There are numerous indications for operation of these individuals. The ones that are generally considered as legitimate reasons are as follows:

1. Painful fixed retro-displacement
2. Adhesions with symptoms
3. Functional uterine bleeding with dysmenorrhea
4. Large hydro-salpinx or tubal ovarian abscess
5. Repeated attacks of infections
6. Possibly certain selected cases of sterility

When an operation is decided upon as a necessity to discontinue the invalidism for the patient, as a result of one or more of the reasons mentioned, we should not forget that conservatism should still be our aim. I think this is true, more so in the cases caused by various bacteria other than the tubercle bacillus.

Tuberculous Salpingitis

In connection with tuberculosis, I have been interested in a report by Hundley of Baltimore, on the incidence of this disease. His survey of 1092 patients with salpingitis revealed only 22 due to the tubercle bacillus, an incidence of .2%. This is a marked decline, if true, and in all probability is, as we have been able to control tuberculosis in general to a greater degree than ever before. The majority of the textbooks list the incidence as 5.7%, Curtis' textbook²⁶, gives an incidence of 5% and Wharton's an incidence of 7.5%.

In tuberculous salpingitis, surgical intervention yields excellent results in many instances. Certainly, the patient should be in the quiescent stage and should not

be operated until the general health is relatively good, as so often is not the case, as there are many times infections elsewhere in the body. If the operation is resorted to, it is advisable to remove both tubes and the body of the uterus. One or both ovaries are usually diseased. If the patient is young, and it is felt at all possible, one of the ovaries should be left, if not too extensively involved. Of course, it is important to remember that drainage in tuberculous infection should never be done because of the danger of secondary infection and the tendency to fistula formation.

Mortality Rate

The operative mortality is about 3%. However, the total net mortality may vary from 10 to 20%, most of the deaths occurring within one year after the operation. A great deal depends upon the type of tuberculous infection found. Surgery has been generally successful in the ascitic and localized parenchymatous forms.

When to Operate

Wharton²² stated that it is far better to operate while there is yet a chance to conserve ovarian function and stresses the importance of not being overly conservative. All agree that chronic pelvic inflammatory disease should be operated on if it causes continued invalidism.

In most cases of other infections, such as gonorrhea, a conservative plan should be uppermost in our minds.

Falk Procedure

Recently, Fried and Kimbrough²³, evaluated the Falk procedure, which was initiated by Dr. Falk some eighteen years ago. His series of cases now number around 1000 and he still maintains, and apparently gets, excellent results from this procedure. Fried and Kimbrough agreed with operative results in 62 cases reported by them. This is a modification of cornual resection of the tube, as described by Falk, and is particularly applicable to recurrent gonorrheal salpingitis. (They were careful in selecting their cases so as not to operate any patient that had an active infection at the time. This was determined by the absence of a rise in temperature, following bimanual examination, plus other signs of active infection; such as leukocytosis and some temperature). Ninety-five per cent of their cases obtained clinical relief.

This type of operation has its merit in that it eliminates interference with normal menstrual function and ovarian blood supply, which if the latter is interfered with, often produces cystic ovaries. In other cases where more radical surgery is necessary, such as removal of the tubes, it should be stressed that the uterus should be removed as well. Many years ago, it was thought that it was better to leave the uterus in place in order to carry on a more rational ovarian function.

Ovarian Tissue Involved

The ovarian blood supply should be interfered with as little as possible, and I do not think that anchoring of the tubo-ovarian ligament to the cervical stump should ever be done as this is not anatomic rationalization. Reperitonealization should be carried out with special care not to strangulate the blood supply to the ovary. Curtis maintains that if only a fragment of an ovary can be saved in order to keep a spark of sex vigor alive, it is better to remove this entirely, as there will be an elimination of a partial menopause over a period of years. He feels that it is much better to have a sudden precipitation of the climacteric than to draw it out over a number of years and have only a small amount of ovarian function. There are many of us who disagree with this idea.

If the cervix is not too badly diseased and can be spared, it is advisable in some of the younger patients, as this will provide a more normal coordination between the ovarian activity and the other pelvic organs and a more physiologic response can be expected.

Pelvic Abscess

There are some cases which progress to a more serious stage and large pelvic abscesses may develop. Occasionally, we still have the opportunity of seeing one of these cases. In these patients, only drainage of the pus will clear the complications. This can be done by colpotomy, if the pus is located mainly in the cul-de-sac or by marsupialization of large pyosalpinx or infected ovarian cysts.

In 1949, Wimpheimer and Epstein²⁴, reported eight cases of marsupialization with satisfactory recovery in seven of these. One expired. This was an infected carcinoma of the ovary.

Although, there is only an occasional instance where one of the latter two operations are necessary, they are still procedures of merit. When there is a large accumulation of pus, there is no drug available that will cure this condition. Drainage is a must.

Summary

In reviewing the literature over a period of many years, we still find that some of the treatments used fifteen to twenty years ago are still sharing an important role in the treatment of the chronic pelvic inflammatory disease. Namely:

1. Heat by means of douches and by sitz bath.
2. Elliott's therapy.
3. Newman's Thermo Flo, etc.

Sulfonamides and the anti-biotics have proven to be of little or no help in most instances.

The treatment described by Jacobson which was discussed in detail and appears to be promising in some cases that failed to respond to other treatments.

Mohler's theory on the possibility of chronic pelvic inflammatory disease, originating from other sources than infection, throws a new light on the etiology of this disease.

The work of Studdiford and Hundley, if proven to be accurate, changes the long accepted theory on the viability of the gonococcus organism.

Conservative surgery certainly should be the uppermost in our efforts and receive our serious consideration. The procedure described by Dr. Falk appears to be the procedure of choice in recurrent attacks of pelvic inflammatory disease.

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The Use Of The Intramedullary Nail

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EMINENCE

Delving into the matter one finds that the use of the intramedullary nail, bar, or pin for the fixation of fractures of the long bones is not new. Lambotte, of Belgium, used an axial wire for fixation of the clavicle in 1907 and 1919; Hey Groves, of England, used an axial pipe for the fixation of a subtrochanteric fracture of the femur.

Due to the hazard of infection, the lack of standard technique, and the lack of a nail that was versatile enough, the method was used only in highly selected cases where standard procedures were not practical.

Early History

Intramedullary fixation was used in this country as early as 1936. Doctors Leslie V. Rush and H. Lowry Rush of Meridian, Mississippi, reported a case they had done in 1936, in the American Journal of Surgery and to the Southern Medical Association in 1937. However, the method gained its greatest popularity in Germany and the Scandinavian countries during the early 1940's. Time Magazine first carried an account of the use of the intramedullary nail in 1942. An American soldier that had been in Germany was returned to a General Hospital in England. On X-raying an old fracture of the femur, the doctors discovered a long metal bar or nail in the medullary canal of the femur. According to the story of the soldier, he sustained a fracture of the thigh and was treated but was not placed in a cast and was immediately ambulatory. Many displaced persons returning from Germany were found to be carrying metal in the marrow canals of their bones.

Treatment of Fracture with Nails

The bulk of the popularity and literature on the intramedullary treatment of

fractures has taken place in Germany. Kuntscher of Kiel, Germany, devised a nail and armamentarium for this purpose and great impetus was given the method by the availability of these nails to the profession. Kuntscher has published a book on the subject of which there is an English translation. There are a good many questions that come to one's mind on the use of metal in the marrow cavity. That is the amount necessary to obtain satisfactory fixation of a given fracture. Those that have observed this method of treatment have felt that it is a safe method and measures up to present day requirements of treating fractures. William T. Fitts and co-workers at Philadelphia report the following results of the effect of *Intramedullary Nailing on the Healing of Fractures*, using the ulna of the dog.

Results Using Ulna of Dogs

"1. The insertion of an intramedullary wire into the dog's ulna fractured experimentally produces callus over an area often far removed from the fracture site. This callus reached its maximum on the roentgenogram at four to six weeks and is gradually absorbed. It appears to have little effect on the healing of the fracture and is not the result of destruction of marrow. We postulate that this callus is caused by the pressure of the wire on the inner cortex and that its disappearance is due to the absorption of bone and the release of pressure.

2. Fractures of the distal half of the ulna heal more rapidly if a wire is inserted through the medullary cavity past the fracture. The more rapid union is probably due to the better immobilization which is effected by the wire and not to any callus stimulating effect of its presence.

3. It is probable that the presence of an inert foreign body in the medullary

cavity does not significantly delay or speed fracture healing."

Description of the Nails

The nail designed by Kuntscher is U-shaped in cross section. The point is beveled on one side to facilitate the introduction of the nail into the medullary canal. At the proximal end there is no head or collar to prevent migration of the nail into the bone. It has the disadvantage of requiring special instruments for the introduction and removal from the bone. The U-shape eliminated the shaping of the nail in the operating room and thus requires having on hand a quantity of nails of various shapes and sizes and curves depending upon the bone to be operated upon.

Street, Hansen, and Brewer, in 1946, described a straight, diamond shaped bar for use in the femur and humerus. Recently Westerborn of Sweden described a nail similar to the Kuntscher nail which is flanged at the proximal extremity.

Doctors Leslie V. and H. Lowry Rush designed a set of pins made of round stainless steel rods. These pins are all straight and of identical construction varying only in diameter and length. The point is shaped like a sled runner and assures its accurate direction down the medullary canal. The shaft of the pin can be curved as the need indicates in the operating room, by the use of a bending iron. There is a hooked, rounded head which prevents migration and allows the pin to be inserted from the extremity or the lateral surface of the bone. When the pin is driven into the bone for a sufficient depth only a small rounded knob extrudes which is not irritating to the soft tissues even in superficial locations. It permits removal simply by inserting the tip of a screw driver and tapping the pin out.

Indications

In the upper extremity it is possible to fix the clavicle, the entire humeral shaft, entire shaft of the radius and ulna and the metacarpals. In the lower extremity the upper two thirds of the femur are very amenable to this method and probably provide its greatest indication. In the lower third of the femur the medullary canal is wide and a satisfactory technic for pinning this region has not been devised. Double pins, one from each con-

dyle, might be the answer.

The medullary canal of the tibia is narrow in its middle half and very secure fixation can be accomplished in this region. The canal widens toward the knee and ankle making fixation in the proximal and distal portions of the tibial shaft less secure.

Complex fractures of the ankle offer a good field for this procedure. Good results have been obtained in cases by passing a pin upward in the fibula from the point of entrance at the tip of the external malleolus and using short pins in the internal malleolus.

Compound fractures have been treated in this manner without infection and the pins were well tolerated.

The primary indication is in transverse fractures when no additional fixation is necessary. Intramedullary nails alone have been found adequate in certain cases of spiral, oblique, and comminuted fractures. When there is much tendency to lateral displacement of fragments, the use of encircling stainless steel wires has been found an advantage.

In multiple fractures, it has been found that the bone can be rigidly re-aligned by threading the fragments upon the pin like beads upon a string. In severely comminuted when the major fragments have been realigned on the pin the minor fragments can often be wrapped about the pin with stainless steel wires to restore continuity of the bone.

Practicability

The method entails essential open reduction. In the reports and talking with those that have done a number of these operations, the open operation is much easier and more satisfactory. After learning the technic, it is much simpler and faster than the application of bone plates. Subperiosteal dissection is not necessary but a small incision is needed for freeing and aligning the bone ends. Soft tissue trauma is minimized and the bone ends are not insulted. The passage of the pin at the time of reduction often simplifies the procedure.

Unlike plate fixation, distraction of the bone ends does not occur. The longitudinal muscle pull in other types of treatment is a major factor to reckon with. In longitudinal pin fixation it becomes the physician's ally.

Safety

From the reports of those that have done a considerable number of fractures by this method, it is as safe as any other method. Though the danger of infection has to be reckoned with, it has not been a condemning factor. There was fear of an increase in the number of emboli but this has not materialized. Nor has there been a disturbance of hemopoiesis.

Conclusions

Surgeons have long sought a safe method of treating fractures that would effect complete immobilization of the bone fragments, allow complete mobilization of the rest of the body and yet not retard bone healing. The intramedullary pin probably comes as close to this goal as any method that has been devised to

date. Those that have used it are very enthusiastic over the results they have had to date. Time will tell as to whether or not it will be generally used for the majority of fractures of the long bones.

If the method continues to work out as it has to date, we have another valuable procedure in our armamentarium for the management of fractures.

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Vagotomy And Pyloroplasty A Simple Safe Solution To The Bleeding Ulcer Problem

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During the past three years we have performed vagotomy alone and in combination with drainage procedures sixty-one times for the treatment of peptic ulcer. During this time we have had occasion to use vagotomy combined with pyloroplasty in the surgical management of ten patients who had bleeding duodenal ulcers. *Our results in these cases, when combined with the results reported over the country, have led us to believe that this procedure is the best answer to the problem of what to do with the patient who is beset with acute or chronic bleeding from duodenal ulcer.

Review of the Literature

Griswold¹ in his discussion of our report on "The Use of Vagotomy and Pyloroplasty for Duodenal Ulcer" commended in particular its use in bleeding ulcer. His comment has been the stimulus for the present discussion. A review of the literature has failed to disclose any re-

ports dealing specifically with this particular problem. Ruffin² has stated that the results of a preliminary nationwide survey on vagotomy in general have shown that recurrent bleeding following this type of operation has been about .3 of 1 per cent in some two thousand cases. The exact number of these cases that gave a history of bleeding was not stated but if one assumes that at least fifteen per cent³ had bled, then three hundred of these patients would fall into this category. Lewison⁴ in his recent collective review of the bleeding ulcer problem communicated directly with several of the leading authorities on gastric surgery and found that all of them had had favorable results with the use of vagotomy in the control of bleeding ulcer. Lewison quotes Moore of the Peter Bent Brigham Hospital as having performed twelve vagotomies for previous painless bleeding ulcer with only a single episode of recurrent bleeding. Crile, Jr., in a personal communication to Lewison stated that he felt that it was the operation of choice for duodenal ulcer and that he had had no episode of

*Since submission for publication we have performed vagotomy and drainage on an additional 30 patients, 8 of whom had chronic bleeding, 3 had acute bleeding. There has been no recurrence to date and no mortality.

post-operative bleeding following some three hundred vagotomies done over a three year period. Dragstedt's letter to Lewison stated that he had performed vagotomy for bleeding ulcer on 99 patients prior to December 1947 with only three recurrences. One of these was found at re-operation to have a single intact vagus fiber. Following division of this the patient had been well for an additional eighteen months. Walters wrote to Lewison stating that his results on bleeding ulcers were satisfactory when using various operative procedures, including vagotomy. Wilkinson of the Lahey Clinic replied that they had had no recurrence in fifteen such cases followed for fifteen months. Ruffin based his impressions upon the personal observation of 100 patients at Duke Hospital, some of whom have been followed up for a period of nearly four years. He says that it is his impression that there have been only one or two cases in the group with post vagotomy bleeding. Lewison states that at Johns Hopkins there have been 7 cases followed for six months with no bleeding.

Mortality Rate

It is most difficult and unfair to attempt to compare the mortality statistics of medical versus surgical management, since only the gravely ill patients are subjected to surgery. However, the fairly high mortality rate which varies from

four⁵ to 8.8 per cent⁴ on cases considered suitable for medical management would seem to indicate that certain of these medically segregated patients would be considered for surgery if the chances of survival of operation and cure could be made more attractive. The magnitude of gastric resection in these extremely poor risk patients has made the internist and surgeon alike most wary of recommending surgical intervention. The operative mortality of "heroic" gastric resection ranges from about 15 per cent to 60 per cent or more in experienced hands. Wangenstein⁶ reports a 20 per cent operative mortality in 10 cases and Gordon-Taylor⁷ reports 18.3 per cent operative mortality in seventy-one cases. Furthermore, gastric resection gives no assurance that the bleeding will not recur in a high percentage of cases. Lahey⁸ reports 33 per cent of recurrence of bleeding following gastric resection. Lewison⁴ reports 50 per cent recurrence following gastric resection in 24 cases at Johns Hopkins. Therefore, it is very easy to understand why internist and surgeon alike have shied away from operation. Even when it becomes apparent to all that surgery must be performed if life is to be saved, the time for such a rescue may be past. To quote Lewison who has paraphrased Rabelais "Surgeons who would not operate when they could, may find that they cannot operate when they would."

Table 1

Data on 6 Patients who gave a definite history of bleeding in the past from proven duodenal ulcer and were treated by means of vagotomy and pyloroplasty because of symptoms other than bleeding

	Date of Operation	Age	Sex	Symptom Duration-Yrs.	Bleeding		Location of Duodenal Ulcer	Hospital Days	Result
					Number	Severity			
1. B.B.	18 Oct. 47	51	F	15	1	Severe	Anterior	7	Excellent
2. S.S.	23 Feb. 48	39	M	10	2-3	Mild	Anterior	7	Excellent
3. B.C.	30 June 48	42	M	12	1	Mild	Superior	6	Excellent
4. A.W.	30 Apr. 49	21	F	3	2	Severe	Posterior	6	Excellent
5. F.A.	25 June 49	38	F	3	1	Moderate	Anterior	6	Excellent
6. G.F.	20 Sept. 49	24	F	4	2	Mild	Anterior	6	Excellent

Mild - Definite anemia with coffee ground vomitus or melena.
 Moderate - Anemia severe enough to produce fainting on two or more occasions.
 Severe - Requiring transfusions, etc.

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Management of Complicated Duodenal Ulcer

We have reported elsewhere our satisfaction with the procedure of vagotomy and pyloroplasty in the management of the complicated duodenal ulcer. Our previous report⁹ included nine patients who had bled prior to operation. Three of our patients were operated upon during hospitalization for massive hemorrhage. We have had one additional patient in this latter category making a total of ten cases to be covered in this report. The factual data concerning these ten patients is shown in tables 1 and 2. In four patients who were operated upon as semi-emergencies the ulcer was attacked directly through the pyloroplasty incision before performing the vagotomy. Two of these patients had actively bleeding anterior wall ulcers which were excised. In these two patients the entire anterior duodenal wall was extremely vascular due to the surrounding reaction; the other two patients had posteriorly situated duodenal ulcers. One of these patients had an actively bleeding vessel in the crater of his ulcer. This was controlled by means of a catgut purse string type mattress suture. This was reinforced by a pledget of oxycel gauze applied as an onlay dressing and tied in place with tie over catgut sutures placed peripherally around the ulcer base. The fourth patient's ulcer, which was situated posteriorly, was seen to contain a fairly firmly attached soft black clot. There was no active bleeding and so this was not disturbed. The exploratory longitudinal gastro-duodenal incision was then closed transversely in each instance,

thereby performing a Heinnie-Mikulicz type pyloroplasty. Vagotomy was then performed after a change of gloves, and careful wound toilet, to avoid soiling the subphrenic space.

Results of Operative Procedure

Our results on these four patients, together with the six others who gave a history of repeated bleeding at some time prior to operation, have been most satisfactory. There has been no recurrence of bleeding or of ulcer symptoms to date. The average follow-up time is 18 months for the entire group. *There has been no operative mortality. The average hospital stay in these ten patients was 6.7 days. The average hospital stay for the patients with acutely bleeding ulcer, including pre-operative time, was 7.2 days.

Conclusion

Thus, we feel that the operation of vagotomy and pyloroplasty is a simple, safe and effectual method of handling any type of duodenal bleeding ulcer. We are satisfied that it will not only control acute bleeding but also will cure the ulcer and thereby will prevent subsequent bleeding. We feel that with this procedure in our armamentarium we can consider the bleeding ulcer problem in the same light that ruptured ectopic pregnancy has been considered in the past; that is, a patient who has massive hemorrhage should be considered as an acute surgical emergency to be operated upon as soon as provision for adequate blood substitution has been made so that the bleeding point can be controlled immediately. *To sit back and hope*

Table 2

Data on 4 patients who were operated upon during hospitalization for severe acute bleeding from proven duodenal ulcers. Vagotomy and pyloroplasty performed after control of bleeding point by direct exposure.

	Date of Operation	Age	Sex	Years Duration Symptoms	Admission Findings			Prev. Bleed.	Blood Replacement	No. Hours Until Surg.	Loc. Ulcer	Hosp Days	Result
					Shock	Hb.	R.B.C.						
7. J.T.	3 Sept. 47	48	M	12	Mild 100/60 P. 100	11.2 gm.	3.6	1 Severe	1000cc	24	Post.	7	Excellent
8. T.N.	29 Apr. 49	36	M	10	Severe 60/0 P. 130	10.5 gm.	3.7	2 Mild	1000cc	48	Post.	9	Excellent
9. S.C.	4 Apr. 50	28	M	3	Severe 70/0 P. 120	10.7 gm.	3.3	0	2500cc	29	Ant.	7	Excellent
10. W.H.	11 June 50	34	M	1	None 140/80 P. 100	17.3 gm.	6.0	0	500cc	12	Ant.	6	Excellent

*Average follow up time now is 22 months, including 11 additional patients.

that bleeding from a good-sized artery will stop spontaneously is to court disaster in a substantial number of cases. To date, all of the statistical evidence is definitely in favor of vagotomy as a treatment for the recurrent bleeding ulcer. Our experience with ten patients with bleeding ulcer would lend support to the idea that vagotomy and pyloroplasty is the operation of choice for this condition.

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Cough

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There is much written in old, musty volumes concerning the cougher and the blood spitter, enough to delight the romantic soul of the most ardent bibliophile. The ancient Hebrew language contained no word for cough. The Hindoos (1500 B. C.) had a word for cough and many drugs for its relief. Thucydides (Ca 455 B. C.), the Greek historian, in describing the great plague (430 B. C.), the pneumonic form of Bubonic plague, lists the symptoms, of which he says, "This I can the better do, as I had the disease myself, and watched its operation in the case of others." He says, "the pain soon reached the chest and produced a hard cough." There are numerous references to cough in the Hippocratic writings.

The poet, Gay, says,

"Oh, happy unown'd youths!

Your limbs can bear

The scorching dog-star and the winters air,

While the rich infant, nurs'd with care and pain,

Thirsts with each heat and coughes with every rain!"

Herbert says, "Love and a cough cannot be hid." Of course, there is a polite cough that warns one of some breach of etiquette or to call attention.

Etiology

But, apart from the poetical side of cough, we recognize it as a forceful explosion of air through the rima glottis, after a full inspiration, aided by the con-

traction of the abdominal muscles. Cough testifies eloquently that there is something irritating the vagus or one of its branches. I know of no brain lesion that precipitates cough. Irritation of the meningeal branch of the vagus may precipitate projectile vomiting. The auricular branch (Arnold's) may, on rare occasions, cause cough, when there is wax or eczema in the ear canal. Irritation of the pharyngeal branch indirectly may produce cough; the pulmonary branch, of course, in pulmonary disease, and in inflammation of the pleura; the esophageal, in diseases of the esophagus does not initiate cough. Irritation of the pericardiac branches of the vagus frequently produces cough such as occurs in adhesive pericarditis (Pick's disease), and secondarily in pericarditis with large effusions by pressure on the trachea. It is questionable whether the gastric branch of the vagus may produce the so-called stomach cough. This is seen sometimes in old alcoholics, but is probably much more likely to be due to pharyngeal irritation.

Classification

We may classify coughs as hacking or pleuritic, wheezy, croupy, gander cough or anuerysmal cough, dry irritative, moist or loose, emetic cough, or sometimes spoken of as Morton's cough (1637-1698 A. D.), paroxysmal, characteristic whooping cough, minute gun cough, hysterical cough and damp weather cough, barking, croupy cough or Cynobex hebetica, seen at puberty in boys in neurotic families. Some have spoken of a uterine

cough, in gynecological cases, due to irritation of the vaginal forinx, referred through the hypogastric plexus. Personally, if there is such, I have not recognized it.

Associated with Infectious Diseases

Someone has said that "the larynx is the watch dog of the lungs." Cough may be associated with any, or all, of the communicable and infectious diseases. Forty years ago it was rather interesting to note the large number of patients with active pulmonary tuberculosis who gave a history of typhoid fever; which was evidently based on inadequate data. Most of these cases had hyperpyrexia and may have been mistaken in their incipency for typhoid. None the less, one of the most consistent and initial symptoms of typhoid fever is bronchitis, which produces urgent cough. Cough is rare in scarlet fever. Measles is notoriously associated with catarrhal symptoms and is more marked in children than any other infectious disease. These cases begin coughing within twenty-four hours.

Prevalence in Children

In children with pertussis, there is one type or organism in which the characteristic whoop is absent, and the diagnosis is difficult. Many of these children have the so-called "minute gun cough," and careful inquiry as to whether or not the child has attacks of emesis is helpful in arriving at a diagnosis.

I have no experience, as to whether dentition is a cause for cough, although it may be a factor. Chronic pharyngitis precipitates cough.

The ordinary hilum adenopathy, such as occurs in the average childhood case of tuberculosis, is not provocative of cough. On the other hand, where there are large caseous nodes pressing on the bronchi, some of which rupture into the bronchus, disseminating the caseous material throughout the bronchial tree, and producing a bronchopneumonia; these conditions are capable of producing a harassing cough.

Importance of History

History is always important in arriving at a conclusion. The child who coughs violently without any prodromal symptoms of infection, or of having caught cold, is strongly to be suspected of a

foreign body. These children cough incessantly. Here the fluoroscopic examination is of inestimable value, especially if due to a non opaque body that may occlude the bronchus. The shift of the mediastinum is characteristic, whereas if a single x-ray is taken, on inspiration, one may miss the diagnosis, unless the compensatory emphysema is marked and the film is technically perfect so as to demonstrate this feature. If films are made on inspiration and expiration, the diagnosis is evident.

Causative Factors

Naturally, children with the adult type of tuberculosis cough. Bronchiectasis, which may be considered a disease of childhood, is a potent causative factor in chronic cough. It has been my impression that children with chronic respiratory infections have rather a poor cough reflex and do not expell secretions as readily as the older groups.

One is impressed with the number of individuals who exhibit allergic phenomenon and all of our histories carry an inquiry as to whether there is any asthma or hay fever in the family, or in the grandparents. This quite frequently will lead one to suspect that the harassing cough is due to an allergic factor. Most of these are non seasonal. If a history of wheezing is ascertained, it helps one assume that the cause is an allergic bronchitis. An inquiry into whether there are any household pets may prove helpful.

Allergy in Children

One case is recalled in which a child coughed violently for three months. On inquiry, the mother stated that the child had had a pair of rabbits given to him at Christmas time; the history revealed that he began to cough from this time on. Removal of the rabbits brought about cessation of the cough.

Another child had coughed violently for many months. There were no pets in the house but the child had a teddy bear, which he took to bed every night in the crib. This was removed and the child was cured of his cough.

Another case in point was a young girl who suddenly began to cough violently. It was recognized to be an allergic tracheo-bronchitis. Skin tests disclosed that the only substance to which she was sensitive was cotton wood, which hap-

pened to be in bloom at that particular moment.

If the allergen responsible for the cough is not apparent, one may begin by a process of elimination of those substances which are most prone to produce allergic phenomenon, such as chicken feathers, eggs and chocolate. One may also elect to use some of the antihistamines, instead of the ordinary cough mixture, to see if these furnish relief.

Extraneous Causes in Children

Osler speaks of a barking, croupy cough in boys at puberty, in neurotic families, the so-called cynobex hebetica; this is a good example of some of the fallacies that become traditional and are handed down from textbook to textbook. Here the old adage is true, "whenever you make a diagnosis, you quit thinking." It is best to keep looking.

In children who are susceptible to colds and frequent respiratory episodes, and who fail to gain weight, one should have in mind fibrocystic disease of the pancreas. This may be present without the pulmonary changes, or even voluminous fatty and foul smelling stools. Where this condition is suspected, it may be well to administer the pancreatic granules, and multiple vitamins, to see what effect it may have on the chronic bronchitis.

Extraneous Causes in Adults

An entirely dissimilar condition obtains in adults where the individual experiences frequent attacks of pneumonia and other respiratory infections, which are considered precursory to multiple myeloma, and here again, it would be well to undertake bone marrow studies where it is suspected.

When we come to adults, we find some of the same conditions obtain, such as allergic bronchitis, which should always be kept in mind.

One is rather surprised to find adult patients from time to time who have had the uvula amputated. Here a profound skepticism is justified as to whether an elongated uvula would be a particular factor in producing chronic cough. It is a dangling temptation, however, to the otolaryngologist. What a tragedy to see cavity tuberculosis in the victim whose recent tonsillectomy was to cure his cough.

One may also be skeptical of irritation in the ear canal as a factor in cough, although it is good practice to examine the ears when no other cause can be ascertained.

A beginning pulmonary abscess is cause for the most violent and harassing cough. Once the tissues have undergone liquefaction necrosis and large mouthfuls of pus have been expectorated, the patient obtains considerable relief.

It is also important to ascertain the time of the day that cough takes place, whether or not the individual coughs on lying down and on arising in the morning.

Chronic bronchitis is one of the chief causes of cough, followed closely by bronchiectasis.

Fumes, especially irritating fumes, such as used in refrigeration, ammonia, when inhaled in concentration, precipitate violent coughing and a very severe tracheo bronchitis and bronchopneumonia.

Welder's disease is a case in point, especially individuals welding galvanized iron and in close quarters. This is characterized by hyperpyrexia, 103°, nausea, vomiting, weakness and cough. It is interesting to note that if the individual is kept out of the industry too long, following an attack of welder's disease, he may have trouble in adjusting himself when he returns to his employment, as many of the men develop a partial immunity.

Tuberculosis Factor

One would be derelict if he did not mention tuberculosis as one of the prime factors provocative of cough. As one wit once said, "Tuberculosis begins with a hacking and a cough and ends with a coffin and a hack." Any young adult who complains of cough lasting longer than three weeks should be completely investigated as to the possibility of it being tuberculous in origin. This is particularly true of those cases of tuberculosis which are characterized by a catarrhal onset. Don't trust to physical examination alone; the safe man is he who knows the limitations of his own art. Tuberculosis is seen before it is heard, and x-ray is an indispensable adjunct to the most meticulous physical examination.

The emetic cough, spoken of as the sign of Morton, after the 17th Century physician, is seen in tuberculous individuals, who, in going through their pulmonary

toilet in the morning, will quite frequently have attacks of emesis without any nausea. Sometimes soapy tooth pastes are prone to precipitate emesis in tuberculous individuals.

A so-called dry, hacking cough is characteristic of pleurisy. Due to the pain the patient refrains from taking a deep breath and pleural irritation produces a short, dry, characteristic cough.

Gander Cough

It is probable today that few medical students see the characteristic gander cough associated with aneurysm of the arch of the aorta, pressing on the trachea, with paralysis of the recurrent laryngeal nerve. The same type of cough may be spoken of as a compression cough due to tumors pressing on the trachea.

Hysterical Cough

Hysterical cough may occur in young women. It is a nervous phenomenon and it is to be noted that these individuals, when in a picture show, and entranced with the film, do not cough during these periods. This, in itself, is suggestive of nervous origin, but the diagnosis, however, should only be made after all other factors have been excluded, and after careful physical examination.

In pneumoconiosis, there is, practically speaking, no cough; the chief symptom being shortness of breath.

Tobacco Factor

Tobacco is a potent factor in chronic cough, which cannot be relieved with medication. It requires complete abstinence from cigarettes for its relief and cure.

Cancer of the Lung

Carcinoma is increasing, especially cancer of the lungs. Middle age individuals presenting themselves to the physician, with the complaint of cough and perhaps blood streaked sputum, always require a consideration of cancer. This is particularly true if the patient complains of pain in the chest and if that is associated with an inspiratory or expiratory, localized wheeze, it is strongly suspicious of cancer in the absence of proved tuberculosis, which may be associated with a wheeze, when endobronchial tuberculosis is present. Pain, however, is the deciding factor, because pulmonary tuberculosis does not produce persistent, localized pain.

Bronchiectasis

In elderly individuals, one quite frequently sees chronic bronchitis associated with emphysema, and in these, cough is a constant feature, especially on exertion, sudden change of temperature, especially cold blasts. Bronchiectasis gives a prolonged history of cough and expectoration with not much impairment in health. This elderly group also is prone to develop any of the conditions that obtain in the young adult and middle age groups.

In those individuals who complain of cough associated with hoarseness, one naturally suspects the larynx and since this is accessible to indirect and direct examination, it should offer no difficulty in diagnosis.

I am excluding cases of mitral stenosis, who show paralysis of the left vocal cord, due to pressure on the recurrent laryngeal nerve, and other intrathoracic affections, which may produce similar findings. Cardiac conditions are to be covered by the other speaker.

Beneficial Coughs

As mentioned above, some coughs are diagnostic in themselves. Cough, in some cases, is quite beneficial. The lungs go through a systole and a diastole, similar to the heart muscle. In the respiratory cycle there is contraction, shortening and folding of the bronchi on expiration, and on inspiration they unfold like a fan, rotate on their axis, dilate and elongate. From this one can see that the pulmonary structures act as a very efficient pump and are capable of ridding the lungs of much secretion. Cough is necessary for the individual with bronchiectasis and the patient with tuberculosis; it is usual for them to go through their pulmonary toilet daily. In terminal stage cases of tuberculosis the cough reflexes are suppressed or blunted, and the patient literally drowns in his own secretions. In far advanced cases of tuberculosis, that are not doing well, the sudden loss of cough is an ominous sign and indicates an impending complication, such as meningitis.

It is not the province of this paper to enter into a discussion of the treatment of cough. In brief, we may consider cough as a symptom, and not as a disease, and it is the duty of the physician to find the underlying cause. This, at times, may challenge all his diagnostic acumen.

Special Article

Planning For Hospital And Health Facilities

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WASHINGTON, D. C.

Each hour, each moment we stand on the threshold of the unknown. This statement holds true for each of us as individuals and also for all of us as a Nation. It is in times such as these that our real worth as free men becomes manifest.

The foundation upon which all of our great progress as a Nation has been built has been our ability to plan for the future. In isolated instances the planning has been done by a single individual, but in the vast majority of times the planning has been the result of the work of many individuals, competent in many skills, getting together, working together, sharing trials and tribulations, but ever pushing forward to achieve the common goal for the betterment of all. That is democracy in action.

All planning is based on recognition of need. One of the greatest needs in our whole country today is adequate health services for our people. We need to maintain and improve the quality of our health services. Equally as important we must extend the scope of these services so that they will be available to those in need of them. This is true in time of peace, but in time of potential war—hot or cold—it is imperative that the health resources of the Nation be mobilized to meet any catastrophe—great or small. Today atomic, bacteriological, radiological catastrophes are a concern of many of our communities. Those of us who deal with services to our fellow men in time of illness have an even greater duty during the preparation for the defense of our Country.

It is well to take stock of some of the important aids available to the Nation in building up our health resources.

In 1946, by the action of the 79th Congress and the President, Public Law 725 established the Hospital Survey and Construction Program. This program, known

popularly as the Hill-Burton Program, was designed basically to assist the states to provide needed hospital and health facilities in needy areas. These areas were primarily rural. The mechanics of this Act have proven it to be one of the most soundly conceived statutes ever enacted by Congress in providing for local, state and Federal cooperation in providing hospital services. It is administered on the state level with the local community retaining the incentive for local initiative and local operation of the completed non-profit, non-discriminatory, community service type of facility. An inventory and analysis by the state of the existing facilities and definition of the need for additional facilities is required before Federal funds become available on a matching basis for construction purposes.

The State establishes the percentage of Federal funds to be made available annually for each project in its borders. The total amount of Federal funds granted to the respective States is determined by a formula in the Law. The controlling factors, however, are population and per capita income of the State.

In 1949 the basic law was amended to include Federal aid for research in the field of hospital services. An appropriation to implement the amendment was under consideration at the outbreak of the hostilities in Korea. With the increased demands on the distribution of our Federal funds there has been no appropriation made available for this type of research.

As of July 31, 1951 a total of 467.5 million dollars has been appropriated for hospital and health center construction. This has made possible the approval of 1600 projects which will provide 77,000 additional hospital beds. An analysis of all the State plans shows that there are in existence today approximately 1,100,000 acceptable hospital beds and a deficit of nearly 830,000. In other words we have only about 54 percent of our needed hos-

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Presented at the Christian County Medical Society, Hopkinsville, Ky.

pital plant in this country at this time.

Of the 1600 approved projects, 475 are completed and rendering a community service, 1000 are under construction and 125 are still in the planning stage. Total construction costs are estimated at slightly more than 1 billion, two hundred million dollars. The Federal share is about 36 percent of this amount.

Of all the projects approved, nearly three-fourths are for general hospitals. This includes new hospitals as well as additions, alterations or remodeling of existing hospitals. Next in order are public health centers—about 15 percent; then mental hospital projects—about five percent; tuberculosis projects—3 percent, with only about 1 percent for chronic disease facilities.

It is apparent that most of the emphasis has been on general hospital facilities. About 55 percent of the general hospital projects are for completely new hospitals. Most of the new hospitals are being built in small towns and in the smaller cities; nearly 61 percent of the new general hospitals are located in towns of less than 5,000 population. Only 7 percent are in cities of more than 50,000 people.

This to me points up the Providential nature of the Hill-Burton Program at this time. There is a duality of purpose noted. I pose the question, "Can not these Hill-Burton Hospitals be regarded as evacuation destinations for our potential target areas." I hope we will never be called upon to put this statement to a test, but we may be. It certainly was not our original purpose.

Of the total Federal funds made available \$15,551,132 has been allocated to Kentucky. State aid to communities has also been granted. To date 47 projects have been approved. 28 are for general hospitals of which half are completely new facilities. The balance is made up of projects that provide for the replacement of old buildings, or for additions or alterations to existing general hospitals. Six projects are located in tuberculosis sanatoria, and four provide additional psychiatric facilities. Seven health centers have been constructed, three of which are combined with new general hospitals.

Two of the projects are located in Hopkinsville and others in this section are at Clinton, Cadiz, Princeton, Owensboro and Leitchfield. With the exception of

Owensboro, these projects will provide completely new facilities.

The provision in the Hill-Burton Act for survey and planning has proved to be one of the soundest features of the law. Each community fits into a pattern of service as outlined in the State Plan. The community must determine the size of the facility that can be supported and the services to be included. The local community planning features are one of the major reasons why the Public Health Service believes that a program for what we now call defense impacted areas, with increased populations, should follow the Hill-Burton concept. Service at the local level is the objective of the program for war impacted areas. Therefore, advice from the communities where the affected people live is essential. Conversely, State and Federal advice to local planning groups is important if the planning is to be really effective. Those involved at all levels should take part in it, not simply be brought into the program after the plans are made.

In addition to the Hill-Burton Program, with its obvious limitations for hospital construction in war impacted areas there are several action programs designed to provide assistance.

The Federal Civil Defense Act does not contemplate the making of grants for hospital construction. It does provide for the incorporation of shelter areas or other construction designed to provide protection of the occupants against enemy attack. Funds, however, are very, very limited.

The bill sponsored by Senator Maybank of South Carolina and Representative Spence of Kentucky known as the Defense Housing and Community Facilities and Services Act was passed by this 82nd Congress and signed by the President. Title III of this Act relates to Community Facilities and resembles in some respects the Lanham Act of World War II. The provisions of this Act include hospital facilities and services for the care of the sick, as well as facilities for water, sewage, sanitation and other community facilities. Federal funds in the amount of 60 million dollars are provided for the construction, maintenance or operation of community facilities. In the case of assistance for hospital construction these funds will be available only if funds are not available under the Hill-Burton Act.

This legislation also provides that maintenance and operation payments will not exceed the portion of the maintenance and operation expenses attributable to the "National Defense Activities in the area." The Act also specifies that the function, powers and duties with respect to health, refuse disposal, sewage treatment, and water purification shall be exercised by and vested in the Surgeon General of the Public Health Service. This latter proviso properly relates the health activities to those existing in regard to the Hill-Burton program. The success of this legislation depends entirely upon local, State and Federal cooperation and coordination of hospital and health services—the kind of cooperation which has proven so eminently effective to date.

The communities in western Kentucky are affected by the defense activities currently taking place at Paducah, Camp Breckenridge, Camp Campbell, Fort Knox and in the T.V.A. areas. It is important that plans be made at once for health resources in this general area. Based on successful planning on other areas this may be accomplished as follows:

First, form a Planning Committee.

Community health planning has many facets. There is need for teamwork among many groups. The key groups are the medical societies and the trained and experienced local public health officials. BUT these cannot do the job alone. The team must have representatives of volunteer health agencies, other professional and educational groups, organizations concerned with fields related to health, and all those groups which might be called consumers of health services.

Second, gather factual data on existing resources and need.

It is estimated that the peak population influx is expected to increase the population of affected communities in this section of Kentucky by about 50 percent. Hopkinsville has already had at least a 12 percent increase. Problems in sanitation, tuberculosis and venereal disease control have already arisen. Hopkinsville has a sanitary land fill system of refuse disposal but other communities in this area have less adequate systems.

Such matters as the role of insects as disease carriers and their control must always be considered.

Resources across state lines must be considered. For example, a 125 bed hos-

pital is being constructed in Clarksville, Tennessee, which may provide for patients from this area if adequate arrangements are made. Data should also be obtained on the provisions needed for mental, tuberculosis and chronic disease patients.

The Public Health Service in cooperation with Commissioner Bruce Underwood of the Kentucky State Health Department made a survey for the Atomic Energy Commission in February 1951 and recommended that 80 hospital beds and an additional nurses' residence were needed to care for the influx population in Paducah. These beds were proposed in addition to the expansion planned for Riverside Hospital under the Hill-Burton Program. It is possible that a 100 bed Baptist Hospital, begun some years ago, may be completed. If the fund drive for the Baptist Hospital is successful and it is erected, will there be a need for additional beds, and if so, how many?

These are typical questions for which answers must be sought by the local communities.

Third, bring to the attention of local community professional and lay groups for the joint study and solution of the problems and for the correlation of all programs and services affecting health—preventive, therapeutic, environmental.

One successful method of filling in gaps in hospital services is by coordination and cooperation among hospitals. There is good evidence that the small hospital cannot—by itself—provide all of the services needed by the people it serves. A solution is to develop relationships among hospitals whereby the larger and more completely equipped can provide the smaller with the needed services.

The concept of a regional hospital coordination system includes many lines of affiliation and sharing among hospitals. For example, such a system envisions interne and resident physician services on a rotating basis to hospitals which otherwise would not have the advantage of such services; (internes for small hospitals are a rare commodity today); the provision of consultation and part time specialist services, including radiology, pathology and other diagnostic services to small institutions; clinical conferences in small community hospitals; educational courses for all classes of hospital personnel; postgraduate training of physicians from small communities; provision for the search for knowledge related to

modern hospital practice in administration and clinical services; stimulation and exchange of information on improved hospital administrative methods; group purchasing; uniform medical records and bookkeeping systems; joint planning of hospital and public health programs. All these are directed toward better patient care and when combined with a proper and adequate hospital licensure law will accomplish better patient care. Coordination of facilities and services indicates the need for a regional planning committee composed of representatives from each of the community planning bodies.

Out-patient departments may be used as a means of alleviating hospitalization in communities where the demand for beds exceeds the supply. Home care programs have aided in this regard. Out-patient service provides one of the best means for hospital participation in preventive medicine, particularly in the fields of mental illness, venereal disease and tuberculosis. Rehabilitation services started early and adequately conducted shorten hospital stay and permit return of the individual to an economically competent status. The results of this type of service pay big dividends, especially in state and other governmentally supported institutions.

Fourth, interpret the findings to the public.

Constant efforts should be made to increase public participation in planning. In this way valuable health education may be accomplished relative to the proper use of existing services and facilities.

Fifth, develop methods of effective implementation of the plan.

The best method to assure this is through education of all the people in the community of the need for it. Planned publicity of the educational type, combined with planned public relations of a high order, are of great value.

The objective of community planning should be to make available to every individual the curative and preventive benefits of medical science at its best. Preventive medicine is a function of every physician and every hospital. Diagnosis, treatment, restoration to health, rehabilitation, prevention of disease and health promotion and health maintenance are the obligations assumed by every physician. The hospital should be the health center of the community. It is the mobilization depot of modern medical science. The practice of medicine should not be confused with the business of medicine by the physician or the hospital administrator; however, the relationships must be understood.

A community health program which combines curative and preventive aspects to attain health promotion and health maintenance will be not only of inestimable value to the defense effort but also will pay great dividends to the sick and the well at any time. The accomplishment of this objective will require dynamic leadership, imagination and cooperative effort of the highest order.

In closing I think it is appropriate to recall the official motto of this great industrial and agricultural State "United We Stand, Divided We Fall."

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An Effort to Find the Answer to the P.-G. Problem

What physician living more than thirty miles from a medical center would not gladly give the fee from an office call to hear an hour of practical, timely, post-graduate instruction, given in his own county society meeting hall?

The seemingly insolvable problem in the past that plagued the promotion of such instruction was that of getting the instructor and busy practitioners together, without loss of time and practice, and the involvement of considerable expense and traveling to one or both.

The Committee on Medical Education believes that the Telephone Seminar, offered to all county medical societies in our Association, February 26, March 18 and April 22, will point to a very effective and economical solution. In a four or five doctor county, the course will average in cost just about that of a call per doctor per hour. In the larger towns the cost may run as low as sixty cents an hour per doctor.

The University of Louisville Medical School, one of the better medical centers in the country, is arranging and presenting these courses without cost. The small fee your county society pays the Association goes toward paying the transmission costs of bringing the program from the University to the telephone company in your community. The only other charge you pay is for bringing the program from your local telephone center to your loud speaker.

Our committee feels that the efforts of the Council and the Medical School in promoting these programs will prove an invaluable service to the physician and the people of our State, and we have been greatly encouraged by your prompt response to our letter.

We believe this program will enjoy a broad acceptance, and we look forward to serving your society and your needs.

ROBERT LICH, JR., M. D., Chairman
Committee on Medical Education

Report To The Medical Profession Of Kentucky On Research Activities At The University Of Louisville School Of Medicine

Behind that door in the photograph are the main clinical laboratories of the University of Louisville Institute for Medical Research. They are located in what used to be the Female Medical Colored ward of the Louisville General Hospital, which was completely remodeled a few years ago for the specific purpose of providing these research facilities. The laboratories contain the most modern equipment, including Geiger counters, gas analysis apparatus, spectrophotometers, electronic apparatus for measuring pressures and for recording measurements, etc.

Behind that door, research work is constantly going on. In these particular laboratories the investigations are altogether concerned with patients, for animal studies are carried out in other laboratories in the Medical School building. Currently, studies under way concern: the therapy of pernicious anemia, especially with Vitamin B₁₂; the effects on the heart and circulation of drugs employed in heart disease, by means of cardiac catheterization, among other techniques; the disturbances in acid-base balance and water metabolism which occur in a variety of disease states, especially of children; the

changes in gastric function which occur in peptic ulcer, especially as they are influenced by therapy, both medical and surgical; and a number of other projects having a definitely clinical application. Already results which have an immediate practical application have followed some of these investigations. In addition, under way are a number of projects of a more basic and fundamental nature, such as the development of newer techniques for measuring the cardiac output and other functions of the circulation.

In those laboratories work a number of full-time and part-time faculty members, including two separate "teams" who are expert in cardiac catheterization; Fellows who are doing postgraduate, full-time Research work; a whole staff of technicians; clerical employees; and a janitor. Because of these facilities, it is not now necessary for patients needing cardiac catheterization for diagnostic reasons to go out of the State for that purpose, for as a service to the State, the Medical School has agreed to do catheterization studies on any patient in Kentucky, when properly referred by his physician.

How was all this made possible? The grant to the Medical School from the State Medical Research Commission made this possible. This grant enabled the School to employ faculty and other personnel and to purchase equipment and supplies which it otherwise could not have afforded. It also made it possible to obtain funds from private sources with which to construct the laboratories of the Institute in which the research work could be done. And finally, once the facilities were provided and the professional staff obtained, it then became possible to obtain grants from other sources with which individual research programs could be expanded, but these grants would not have been forthcoming had it not been for the basic assistance rendered by the grant from the State Medical Research Commission.

J. MURRAY KINSMAN, M. D., Dean
U. of L. School of Medicine

Editor's Note: The above report was prepared upon request by the Med. Research Commission for the information of the profession.



ORGANIZATION SECTION

County Officers Conference To Feature Five Nationally Prominent Speakers, Feb. 7

A. M. A. Pres.-Elect Is Luncheon Speaker At Session In Brown Hotel In Louisville

Four nationally prominent specialists in medical organizational activities, including Louis H. Bauer, M. D., New York, President-Elect of the A.M.A., will be presented at the Second Annual County Society Officers' Conference, February 7, in the South Room of the Brown Hotel in Louisville, Clyde C. Sparks, M. D., Ashland, Chairman of the Council, has announced.

Other features of this daylong meeting, sponsored by the Council, will include an address by a widely-known farm leader, explanations of current K.S.M.A. programs, individual district councilor conferences and a legislative forum, Dr. Sparks said. There will be no discussion following each address, but question-and-answer periods will be provided at the conclusion of each half day session.

Invited to the conference are all county medical society officers; the chairmen of the county legislative, public relations and rural health committees; officers and councilors of the state association and the chairmen of all K.S.M.A. state committees.

In addition to Dr. Bauer, other guest speakers will include Carl F. Vohs, M. D., St. Louis, a pioneer in Blue Shield organizational work; John T. T. Hundley, M. D., Lynchburg, Virginia, current president of the Medical Society of Virginia, who has distinguished himself as an exponent of practical public relations' methods; and Miss Charlotte Rickman of Raleigh, North Carolina, consultant on rural health of the North Carolina State Medical Association. Mr. J. E. Stanford, executive secretary of the Kentucky Farm Bureau Federation, will address the conference during the afternoon session.

The individual councilor district conferences, which proved so popular last year, will all convene at the same time—just before the luncheon meeting. These sessions make it pos-

sible for the officers of the districts to discuss their problems with their councilors.

The headquarters office has been directed to send detailed information on the program to all who are invited to the conference. Included in this material will be a self-addressed post card which the officers are urged to complete and mail immediately.

Clark Bailey, M. D., Harlan, K.S.M.A. President, has urged all of the county medical societies to submit the names of new officers and committee chairmen to the headquarters office, 620 South Third, Louisville, at their earliest convenience. This will make it possible for the new officials to receive information on the conference and make plans to attend.

AMA Abolishes Fellowship Dues

The American Medical Association has abolished "Fellowships" and discontinued the payment of the \$5.00 "Fellowship dues," in action taken by the Board of Trustees prior to the Los Angeles meeting. The Board felt that the dues were no longer required since A.M.A. members are now paying membership dues, and that, furthermore, the Fellowship dues requirements were too confusing to members as a whole. Fellowship dues of \$5.00 for 1951 are still payable.

Jaundice Is Topic of Telephone P. G. Broadcast, Feb. 26

"Management of the Patient with Jaundice" is the subject matter to be considered on the first telephone seminar, to be given the evening of February 26 under the sponsorship of the Kentucky State Medical Association in cooperation with the University of Louisville School of Medicine.

The announcement was made by Herbert L. Clay, M. D., Louisville, the director of postgraduate refresher training at the University of Louisville. Subjects for the subsequent, hour-long postgraduate instructional broadcasts, to be given March 18 and April 22, and names of participants on the program will be made known at an early date.

The subject for the first broadcast will be considered as follows:

(1) Classification and Definition of Types of

Jaundice (5 minutes)

- (2) Differential Diagnosis and Evaluation of Laboratory Tests
- (3) Treatment of Medical and Surgical Jaundice
- (4) Questions and Answers

The members of the panel are: Walter S. Coe, M. D., Assistant Professor of Medicine, who will serve as moderator; Marion F. Beard, M. D., Associate Clinical Professor of Medicine; William M. Christopherson, M. D., Assistant Professor of Pathology; and George B. Sanders, M. D., Assistant Clinical Professor of Surgery.

Telephone broadcasts of this nature are enjoying their second year of success in Indiana with more than half of their county societies participating. Texas has undertaken the project for the first time for the 1951-52 season and it is well accepted there. The K.S.M.A. broadcasts are under the supervision of the Committee on Medical Education. Robert L. Lich, M. D., Louisville, is chairman.

Kentucky Academy Plans Day-Long Medical Session, Apr. 30

The Kentucky Academy of General Practice will sponsor a day-long meeting in Louisville at the Kentucky Hotel on April 30, Richard R. Slucher, M. D., Buechel, President, has announced.

Philip Thorek, M. D., a Chicago surgeon, will be among the distinguished guest speakers from out of the state, Dr. Slucher said.

Another feature of the program will be the luncheon. The program for this session and the scientific meeting will be given by outstanding talent. All Kentucky physicians will be invited.

McDowell Pageant Wins Top Honors in SMA Program Contest

The pageant "Living Pictures," illustrating the life of Ephraim McDowell, which was presented by the Woman's Auxiliary to K.S.M.A. at the General Public Meeting during the Centennial, won Kentucky first place in the annual "Doctor's Day" program contest of the Woman's Auxiliary to the Southern Medical Association.

The award was announced by the Southern Auxiliary at the annual meeting of the Southern Association, held in Dallas, Texas, November 5-8, and a prize of \$15.00 was presented to the Kentucky Auxiliary.

An outline and description of the historical

tableaux had been submitted by the K.S.M.A. Auxiliary to the Chairman of "Doctor's Day" programs for the S.M.A. before the meeting occurred. The program was given here under the general direction of Mrs. Clark Bailey, Harlan, 1950-51 president of the Auxiliary.

Outstanding Program Planned for 1952 Annual Meeting

The Committee on Scientific Assembly has been given a free hand by the Council in arranging the Scientific Program for the 1952 Annual Meeting in Louisville, October 7, 8 and 9, according to Clark Bailey, M. D., Harlan, President.

The committee is arranging a scientific program which will be as well balanced as possible and, while set up primarily for the physician in general practice, it will carry a broad appeal, Dr. Bailey said.

Outstanding talent is being sought with approximately half of the essayists being men who have distinguished themselves and their practice in other states. Every effort will be made to select the best talent among our own membership, the President stated.

"The unusually strong scientific program of our Centennial Meeting, presented by Kentucky born and Kentucky trained physicians who had distinguished themselves beyond our borders, was a splendid achievement for our Association," Dr. Bailey said. He continued with "It pointed up the many contributions that such a program makes, and in 1952 we expect to have the best program possible through the resources available to us."

Fayette County Hears President Bailey at Dec. 11 Session

"The Transition of Medicine" was the subject of an address delivered by Clark Bailey, M. D., Harlan, K.S.M.A. President, to the Fayette County Medical Society at its regular monthly meeting, December 11, in Lexington.

Bruce Underwood, M. D., Louisville, Secretary and General Manager of the Association, was also a guest of the society, along with Mr. J. C. Wash, a representative of Blue Cross and Blue Shield. Both men made a brief talk to the group, and answered questions in the discussion that followed.

Dr. Bailey discussed some of the major issues before medicine today. He included the threat of socialism, the problems of physician-hospital relationships, labor and industry relationships, and activities of some of the so-called healing arts group.

The president touched on the activities of the A.M.A. and then outlined the broad K.S.M.A. program, and explained the work of the various agencies. The legislative aims of the Association were discussed.

At the conclusion of the meeting, the Fayette County Society elected Richard G. Elliott, Jr., M. D., President; Rankin C. Blount, M. D., Vice-President; and John B. Floyd, Jr., M. D., Secretary. William H. Pennington, M. D., is the retiring president, and John S. Sprague, M. D., is the outgoing secretary.

ACS Elects 15 State Surgeons As Fellows at San Francisco

Fifteen Kentucky physicians were made Fellows in the American College of Surgeons, which received 903 initiates into fellowship at the closing session of its 37th Annual Clinical Congress in San Francisco, November 9.

Evarts A. Graham, M. D., St. Louis, was appointed to succeed Arthur W. Allen, M. D., Boston, as Chairman of the Board of Regents of the American College of Surgeons. Dr. Graham is emeritus professor of surgery, Washington University School of Medicine, and emeritus surgeon-in-chief, Barnes and St. Louis Children's Hospital.

The new Kentucky members of the A. C. S. are:

Jack C. Blackstone, Owensboro; W. Burford Davis, Louisville; W. McDaniel Ewing, Louisville; Clyde H. Foshee, Louisville; Joseph M. Frehling, Louisville; Henry S. Harris, Bowling Green; James E. Hix, Owensboro; Lawrence E. Hurt, Lexington;

Kenton D. Leatherman, Louisville; Nathan Levene, Louisville; William T. McElhinney, Covington; Alvin C. Poweleit, Covington; Otto H. Salsbery, Covington; H. Lowell Shanklin, Louisville; Houston W. Shaw, Louisville.

Industrial Health Congress to Convene January 18 and 19

The Twelfth Annual Congress on Industrial Health will be held at the Hotel William Penn in Pittsburgh on January 18 and 19, 1952, under the sponsorship of the A.M.A.'s Council on Medical Services, Assistant Secretary of the Council, J. F. McCahan, M. D., Chicago, has announced.

Gradie R. Rowntree, M. D., Louisville, Chairman of the K.S.M.A. Committee on Industrial Medicine and Surgery, will attend the meetings.

The Conference of the Council and Chairmen of the State Committees on Industrial

Health is scheduled for January 17, the day preceding the Congress. This joint conference, which was held for the first time last year, is designed to acquaint the Council and the State Committees with the work of each other and to improve teamwork.

AMA Awards Indiana Physician Family Doctor Medal

A. C. Yoder, M. D., Goshen, Indiana, was elected "family doctor" of the year by the American Medical Association's House of Delegates at the winter meeting in Los Angeles, December 4, and received the A.M.A.'s gold medal award for outstanding service to his community.

Dr. Yoder, who is 84, is the fifth recipient of the honor. A graduate of Rush Medical College, Chicago, in 1902, he has practiced medicine in Goshen continuously since that time, and still maintains office hours six days a week.

John E. Kincheloe, M. D., Hardinsburg, was selected by the K.S.M.A. House of Delegates as the outstanding general practitioner of the year in Kentucky, and was presented the J. Watts Stovall Award at the Centennial Meeting in October. Dr. Kincheloe competed with other state award winners for the A.M.A. honor.

Dr. Llewellyn Tells Student AMA Of Membership Advantages

The Kentucky Chapter of the Student American Medical Association was addressed by John S. Llewellyn, M. D., Louisville, K.S.M.A. representative to the local S.A.M.A. Advisory Committee, on Friday noon, December 12, 1951, in the General Hospital Amphitheatre. Dr. Llewellyn spoke on the subject "The Student American Medical Association, its objects, purposes, and potentialities."

Dr. Llewellyn told his audience that the American student medical association is somewhat tardy, as other countries—Austria, Italy, Switzerland, the Netherlands, Norway, France, Great Britain, Canada and even India—had recognized the need for and formed such associations before we had.

Pointing out the benefits and advantages of membership in the junior association, he emphasized the monthly Journal of the Student A.M.A., which will make its initial appearance in January; the films, which are available to chapters without cost; the package library service, which brings by mail material that cannot be obtained through local library facilities.

ties; the Speakers' Bureau of well-qualified men available for student meetings; and the various other plans for the new student organization.

These include a fund for loans and grants to medical students for continuing their education, a proposed arrangement for establishing hospital and surgical insurance to cover medical students, and plans to maintain a placement service with listings of localities without physicians and physicians without locations, the same service acting as a clearing house for job and research opportunities, Dr. Llewellyn disclosed.

AMA Donates Another \$500,000 to Medical Education Fund

The American Medical Education Foundation has received another half million dollars from the American Medical Association, Dwight M. Murray, M. D., Napa, California, Chairman of the A.M.A. Board of Trustees, announced at the 1951 winter meeting of the A.M.A. in Los Angeles, California.

The Medical Education Foundation was established at the December, 1950, meeting of the A.M.A. in Cleveland, at which time the Board of Trustees announced the initial appropriation of \$500,000 as the nucleus of a fund to be raised by the medical profession to assist medical schools. Since then, an additional \$250,000 has been contributed by national, state and local medical societies and through individual donations, and that sum was distributed this past summer.

The president of the Foundation is Elmer L. Henderson, M. D., Louisville.

J. Duffy Hancock, M. D., Louisville, has been appointed chairman of a K.S.M.A. committee to promote individual donations to the Foundation. Dr. Hancock will announce the personnel of his committee and plans for its work in an early issue of the Journal.

Election Year Ahead Is Critical Dr. Henderson Tells A.M.A.

"The election year ahead is perhaps the most critical year of the medical profession's existence as a free society," said Elmer L. Henderson, M. D., Louisville, chairman of the A.M.A. Campaign Coordinating Committee, in a report to the House of Delegates at the A.M.A. meeting in Los Angeles, December 4.

Dr. Henderson said that before another year has passed "the die will be cast as to who will be responsible for the health of Americans in the future—whether medical men, or politi-

cians of socialistic persuasion. The character and caliber of the men elected to Congress next year and to the high administrative offices of our nation, will determine that vital issue."

AMA Pres.-Elect to Address Local Student AMA Chapter

Louis H. Bauer, M. D., Hempstead, New York, President-Elect of the A.M.A., will address the University of Louisville Chapter of the Student A.M.A., February 7, in the amphitheatre of Louisville General Hospital, Charles J. McGaff, Louisville, President of the local chapter, has announced.

Dr. Bauer will also be the luncheon speaker at the second annual county society officers' conference to be staged at the Brown Hotel, Louisville, on February 7.

The local chapter is a charter member of the Student A.M.A. and has 149 paid members. Other officers of the chapter are: William Ackerly, Louisville, Vice-President, Wanless Mann, Mannsville, Treasurer, and Martha Harmon, Louisville, Secretary.

Small Cost, Convenience, Add To Telephone Seminar Appeal

"The response of the component county medical societies to the Association's announcement of the telephonic broadcasts of the Post-graduate Instructional Course has been most encouraging," Robert L. Lich, M. D., Louisville, Chairman of the Committee on Medical Education, has said.

"Because this undertaking is our initial effort, there will be some lack of understanding in methods of procedure, costs, etc., but," Dr. Lich continued, "the counties still have ample time to let us help iron out any difficulty in time to arrange for the course, and they are urged to contact us at the headquarters office, 620 South Third, Louisville."

The cost is so small, the convenience is so great, and the procedure is so simple, that it is hard to believe, the Chairman said. As to cost, the average cost per member of a four-physician society for the hour-long programs, is about \$4.00.

The convenience of the plan is in that it makes it possible for most men to hear the broadcasts without leaving their community. The caliber of the material presented could not be improved upon, even if the doctor traveled 150 miles to a medical center to hear it, it was explained.

K. S. M. A. Members, Delegates Attend A. M. A. In Los Angeles

A total of 3550 physicians had registered by the close of the second day for the Fifth Annual Clinical Session of the American Medical Association, which was held in Los Angeles, California, December 4, 5 and 6, 1951. According to the A.M.A. daily bulletins, the following doctors attended from Kentucky:

J. Duffy Hancock, M. D., Louisville; Elmer L. Henderson, M. D., Louisville; J. B. Lukins, M. D., Louisville; Earl J. McCracken, M. D., Louisville; D. G. Miller, Jr., M. D., Morgantown; and Bruce Underwood, M. D., Louisville.

Dr. Hancock, Dr. Lukins and Dr. Underwood represented the K.S.M.A. as Delegates to the A.M.A. meeting.

McGaff Is Student A.M.A. Delegate

Charles J. McGaff, Louisville, a member of the junior class at the University of Louisville School of Medicine, was elected by the local Chapter of the Student A.M.A. to attend a meeting of the House of Delegates of the Student A.M.A., that was scheduled to meet in Chicago, December 27 and 28. Mr. McGaff is the president of the University of Louisville chapter. The local Chapter of the Student A. M. A. has been recognized as a campus organization by the University of Louisville Student Council.

Pertinent Paragraphs

The Board of Trustees has established the following exemptions from the payment of American Medical Association dues: (1) Members who have retired from the practice of medicine, provided they have local dues exemption; (2) Members over 70 years of age, regardless of whether or not they are in practice and regardless of local dues exemption; (3) Members for whom the payment of dues constitutes a financial hardship and who are also excused from the payment, in full or in part, of local dues; (4) Interns and residents not more than 5 years after graduation, except that time spent in military service may be excluded in calculating the 5 years; (5) Members who enter military service prior to July 1 of any year are exempted from one half of the year's dues and subsequently during service from full dues.

Robert J. Wilkinson, of Huntington, West Virginia, was installed as president of the Southern Medical Association at the 45th annual meeting in Dallas, Texas, November 8, the closing day of the session.

He succeeds Curtice Rosser, M. D., of Dallas, and will hold office until the next annual meeting which will be held in 1952 in Miami, Florida. Dr. Wilkinson is the third West Virginia doctor to serve as president of the Southern Association.

Senator Robert A. Taft, Ohio Republican, and Senator Harry F. Byrd, Virginia Democrat, spoke before a special meeting of the A.M.A. House of Delegates during the Fifth Annual Clinical Session of the A.M.A., December 5. The senators linked forces to drive home a sharp warning against the dangers of "creeping socialism." Socialized medicine is only the "opening wedge" in the door to socialism, Senator Taft said. Senator Byrd told the audience, "The A.M.A. has waged a clean, aboveboard campaign against socialized medicine. You realize that socializing an important segment of our daily life means that sooner or later further socialism will encompass other activities."

Land has been secured in Harlan and Wheelwright, Kentucky, and Beckley and Williamson, West Virginia, for the building of hospitals by the United Mine Workers Welfare and Retirement Fund. Ten hospitals are projected, which will be built so they can be enlarged later if necessary.

The Clinical Conference of the Chicago Medical Society will be held March 4, 5, 6, and 7, 1952, in the Palmer House, Chicago. In addition to the regular series of lectures, an increased number of work shop periods will be given this year. Address requests for programs to Chicago Medical Society, 86 East Randolph Street, Chicago 1. All physicians are invited.

The Senate Finance Committee dropped the Ives amendment from its revenue bill September 18, the Washington office of the A.M.A. reports. The amendment would have permitted certain professions (physicians, dentists, lawyers, engineers, etc.) to deduct from taxable income a limited amount of money used for insurance annuities. Senator Ives and the committee felt that not enough study has been made of this plan. Several members of the Finance Committee have agreed to study the proposal more thoroughly next year.

The Medical Civil Defense Conference, sponsored by the A.M.A., the American Hospital Association and the Association of State and Territorial Health Officers, at the Palmer House, Chicago, in November drew an attendance of 250, the largest crowd ever to attend a medical meeting of this kind, George F. Lull, M. D., A.M.A. Secretary, has announced. A resolution was passed unanimously by the conference calling for all medical personnel to be assigned appropriate places in their local civil defense organizations, after full consultation with the local, state or national health organizations.

Federal Civil Defense Administration has been appropriated the funds for its 50-50 U. S.-state medical stockpiles, but a majority of the states still have not sent plans to Washington for approval, according to the A.M.A. Washington office. Under the master plan, these stockpiles are expected to take care of casualties during the first 4 hours after an attack. By then, it is expected that supplies will be received from regional stockpiles, set up and maintained entirely by federal funds. So far, only 12 state plans have been filed with the Armed Services Medical Procurement Agency.

Senator Richard M. Nixon (Rep., California) has warned doctors against a complacent attitude as regards socialized medicine and a cessation of interest in politics, reports a public relations bulletin of the Pennsylvania State Medical Society. The Senator said that doctors, in carrying out their political action, should remember 2 basic rules: (1) A good offense is the best defense; and (2) actions speak louder than words. As a good example of such actions, he cites the voluntary contributions doctors are making to medical schools.

A panel discussion on "Diabetes," sponsored by the Council on Diabetes of the Cincinnati Public Health Federation, will be held in Cincinnati at the College of Medicine auditorium on Thursday, January 17, at 7 p.m. All physicians are invited to the meeting. Those who plan to attend may submit questions to the panel by mailing them, in advance, to the Council on Diabetes, 312 West Ninth Street, Cincinnati 2, Ohio.

Regional 1-day institutes on cardiovascular diseases were held in Covington, Ashland, Harlan, Owensboro and Lexington recently, sponsored jointly by Kentucky State Association

of Registered Nurses, Kentucky State Organization for Public Health Nursing, Kentucky Dietetic Association, Kentucky State Department of Health, Kentucky Heart Association and its local affiliates, Miss E. Alice Clark, R. N., Coordinator, Program Committee, has announced. All nurses, dietitians, student nurses and allied professions interested in heart disease problems were invited to attend.

New York City is to construct one of the largest hospital and medical centers in the country, costing an estimated 61½ million, according to a News Letter from the N. Y. State Medical Society. The heart of the center will be the new Yeshiva University Medical School, which is expected to train 400 students. The City has offered the facilities of the new Bronx Municipal Hospital Center to the new medical school.

The fluoridation of community water supplies to reduce the incidence of tooth decay among school children is a safe procedure, the A.M.A. reported in the December 1 Journal. The Council on Pharmacy and Chemistry and the Council on Foods and Nutrition of the A.M.A. issued a joint statement, saying that there was not now evidence of toxicity which would deter cities from fluoridating the water supplies as a partial protection against tooth decay.

The Health Insurance Council has estimated that approximately 60% of the employed civilian population have subscribed to voluntary health protection plans, it was reported in its fourth Annual Survey.

The new Journal of the American Diabetes Association, entitled DIABETES, will appear bimonthly beginning with the Jan.-Feb. 1952 issue, J. Richard Connelly, Executive Director of the Association, has announced. It will be the Association's official scientific and organizational publication, replacing its annual PROCEEDINGS and its quarterly DIABETES ABSTRACTS, both of which have been published for the past 10 years.

A Bulletin on Rheumatic Diseases, published monthly by the Arthritis and Rheumatism Foundation, will be sent without charge to any physician who would like to receive it. Send name and address to Gideon K. de Forest, M. D., Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 19, N. Y.

President's Page

A New Year is in its infancy. It finds many individuals and large groups of organized people attacking the profession of medicine and its practices. Some would completely organize medicine as subversive to the state and would benefit politically. Some are prejudiced. Many are sincere. Many are misled. The greatest campaign of propaganda via the smear technique ever directed toward medicine is being waged. Medicine is being attacked from all sides. An almost unlimited source of finances is available and is being used by leaders of excellent ability to completely control or destroy medicine as we know it. The coming presidential campaign will see medicine in a very unhappy position due to the expected false accusations and twisted half-truths that will be broadcast into every American home. The enemies of medicine do not want to understand the problem. They do not want to be of a helpful attitude. They want only to control or destroy.

Our relative status as a profession is ironical when we think of the superlative progress of medicine, its increased service and facilities, its search for truth translated in greater relief of suffering

of our fellow men. In contrast, it is apparent that government, much of labor, and many other groups which are fighting medicine, are in a process of deterioration, and are destructive rather than constructive. Am I right when I doubt their sincerity of purpose? The motive of greed and the desire of control and power by men of intellectually dishonest ideals, supported by government and powerful pressure groups, has made medicine a very sick patient.

The only way the trend can be reversed is for every doctor to participate in the activities of his medical society at the county, state, and national level. If we give our support in a spirit of unity no one or more destructive groups can retard our march of progress. Through the active participation of all of our members we shall not only withstand the thrusts from without but will make of our own organization a tower of strength from within that is an example of democracy and a foe of bureaucracy.

Unless we realize our great danger, the necessity of standing together as one, and of working together as one—we shall have a Korean peace.

Clark Bailey

PRESIDENT

County Society Reports

JEFFERSON

The October meeting of the Jefferson County Medical Society was held Monday evening, October 15, 1951, at the Seelbach Hotel. 85 members were present for dinner.

The meeting was called to order at 7:45 p.m. by Harry Andrews, M. D., First Vice-President, who presided in the absence of Lytle Atherton, M. D.

The Secretary read the minutes of the last meeting, which were approved.

Joseph Bell, M. D., Chairman, Executive Committee, read recommendations of the Committee on several communications referred to the Committee. (1) They commended the Medical Advisory Committee to the National Foundation for Infantile Paralysis for excellent work being done; (2) cited the Constitution and By-laws with reference to applications by dentists for membership in the Society; (3) approved the revised and enlarged telephone advertisement on Emergency Medical Service; (4) with reference to the Professional Service Committee's report on Physician's Exchange, the Executive Committee recommended that the President appoint a committee to study the present set-up of the Physician's Exchange and make a report of their findings and recommendations at the annual meeting at the end of the current year.

Motion was made by David Cox, M. D., that the report of the Executive Committee be accepted. This was seconded and carried.

The following new members were elected: Active Membership—Drs. W. L. Corum, Robert J. Lehman, H. Oppenheim, Robert J. Seebold, David Shapiro. Associate Membership—Drs. Clarence C. Starr, Gerald A. Barnaby, Verne V. Eskridge, James R. Freedman.

The Secretary read a clipping from the Courier-Journal regarding the Flag Exchange Program of the U. of L. International Center, and a letter inviting the Society to participate by purchasing a flag to be exchanged with a member nation of the United Nations.

Motion was made by Jesshill Love, M. D., that the Society participate, by purchasing a nylon American flag at a cost of \$14.10, was seconded and carried by a vote of 16 to 15.

Margaret A. Limper, M. D., presented the request of the Council on Maternal and Child Health to the Division of Maternal and Child Health of the State Health Department that the Society appoint a committee on Fetal and

Maternal Mortality to study all fetal and maternal deaths in Jefferson County, this committee to consist of a general practitioner, obstetrician, pediatrician, pathologist and an anesthesiologist.

Dr. Limper made a motion that the Society appoint such a committee, which was seconded and carried.

SCIENTIFIC PROGRAM: 8:05 P. M.

Symposium on the Malignant Lymphomas (Program presented by the Jewish Hospital, Division of the University Center), Martin H. Boldt, M. D., Moderator.

1. "Classification and Pathological Aspects." A. J. Miller, M. D.

2. "Medical Aspects—Pitfalls in Diagnosis." Martin H. Boldt, M. D.

3. "Cutaneous Manifestations." A. B. Loveman, M. D.

4. "Newer Trends in Therapy." David Shapiro, M. D.

There was discussion by G. M. Peterson, M. D., W. U. Rutledge, M. D., and Jesshill Love, M. D.

Adjourned: 9:25 P. M.

Austin Bloch, M. D., Secretary

MUHLENBERG

The regular meeting of the Muhlenberg County Medical Society was held November 2, 1951. Members present were Claude Wilson, M. D., John P. Walton, M. D., Frank A. Bechtel, M. D., Richard E. Davis, M. D., George H. Rodman, M. D., and George F. Brockman, M. D.

The meeting was called to order by the acting president, Dr. Rodman.

The minutes of the preceding meeting were read and approved.

The secretary reported various routine communications. In addition, a reply had been received in regard to the Society's request for information regarding the endemicity of the virus hepatitis in Kentucky, which had been addressed to the State Health Department. The secretary was instructed to make further efforts at securing sufficient information.

Dr. Davis presented observations on the need of, and the possibilities for, additional nurse recruitment. General discussion followed. The Society being in favor of additional effort, the secretary was instructed to call this matter to the attention of the Auxiliary.

Dr. Bechtel reported interesting observations on a biopsy-proven case of Hemachromatosis in an elderly female. Dr. Bechtel was instructed by the Society to submit this for consideration for publication in the State Medical Society Journal.

On motion, the meeting was adjourned.

George F. Brockman, M. D., Secretary

MUHLENBERG

The regular meeting of the Muhlenberg County Medical Society was held November 16, 1951. Members present were Frank A. Bechtel, M. D., George F. Brockman, M. D., Richard E. Davis, M. D., George H. Rodman, M. D., and Hylan H. Woodson, Jr., M. D.

The meeting was called to order by Dr. Davis, in the absence of the President.

The minutes of the preceding meeting were read and approved.

Dr. Davis, of a special committee on Nurse Procurement, reported additional progress in securing commitment to nursing school vacancies for our applicants.

Dr. Brockman presented a case currently under treatment. The patient is a dermatological problem of many months duration, and is felt to have penphigus or a dermatitis of allergic origin. It is currently hospitalized for hormone therapy. Broad general discussion followed.

On motion, the meeting was adjourned.

George F. Brockman, M. D., Secretary

SCOTT

The regular monthly meeting of the Scott County Medical Society was held at twelve o'clock noon on Thursday, December 6, 1951, at the John Graves Ford Memorial Hospital, with the following members present:

W. S. Allphin, M. D., L. F. Heath, M. D., D. E. Clark, Jr., M. D., H. G. Wells, M. D., F. W. Wilt, M. D., E. C. Barlow, M. D., A. F. Smith, M. D., and H. V. Johnson, M. D.

Motion was made and seconded that we have our meetings downtown in the future as it does not suit the Hospital to serve us. Carried.

Dr. Clark made a report on the Diabetic Drive in Scott County.

Election of officers for the coming year was as follows:

President, Dr. Clark; Vice-President, Dr. Heath; Secretary and Treasurer, Dr. Johnson; Delegate, Dr. Wells; Alternate, Dr. Clark; Censor, Dr. Allphin, 3 years.

Drs. Wells and Wilt were appointed to investigate the selection of Trustees for the new Hospital and report back at the next meeting.

The Treasurer made a financial report for the past year showing receipts and disbursements.

The meeting adjourned to meet on the first Thursday in January, 1952.

H. V. Johnson, M. D., Secretary

SHELBY-OLDHAM

M. H. Skaggs, M. D., was host to the Shelby-Oldham Medical Society at the Stone Inn on November 29th.

The following members and guest were present:

Drs. A. C. Weakley, B. B. Sleadd, M. T. Alexander, W. H. Nash, W. P. McKee, M. D. Klein, L. B. Sternberg, M. H. Skaggs, H. B. Mack, E. G. Houchin, H. H. Richeson, George Ray, George Perrine, Wyatte Norvell, L. A. Wahle, A. D. Doak, C. C. Risk and Scott McAlister.

After the turkey dinner the meeting was called to order by the President, Dr. Nash.

The Secretary read a letter from the State Association in regard to the telephone broadcast that will be made to the County Societies in February, March and April, 1952. It was voted to contract for this service and assess each member \$2.00 to defray the expense.

On motion, the Secretary was instructed to write E. L. Henderson, M. D., Past President of the American Medical Association, a letter of appreciation for the wonderful work he did in the fight on socialized medicine.

On motion, the immunization of children for diphtheria, whooping cough, tetanus and smallpox, the program that is put on by the Division of Maternal and Child Health throughout the State was adopted.

It was impossible for our guest speaker, Dr. E. L. Henderson, to be present, but he had asked Dr. Scott McAlister to read his paper. The paper outlined the work that was done by the A.M.A. during the last year and special stress was made in regard to socialized medicine.

Meeting adjourned at 9:30 P. M.

C. C. Risk, Secretary

News Items

Richard F. Grise, M. D., has opened an office in Bowling Green, and will limit his practice to surgery. A native of Bowling Green, Dr. Grise is a graduate of Vanderbilt University School of Medicine in 1944. He has recently completed a residency at University of Virginia Hospital, Charlottesville.

Samuel T. Jones, III, M. D., has located at Crummies, Harlan County. A graduate of Tulane School of Medicine, Louisiana, in 1950, he has just completed an internship at Charity Hospital, New Orleans.

Robert L. Jones, M. D., has announced the opening of an office in Fulton. He is a graduate of University of Tennessee College of Medicine in 1950, and interned at Jefferson Davis Hospital, Houston, Texas.

W. E. Nichols, M. D., Manchester, announces his association with **Theodore B. Thoma, M. D.** Dr. Thoma is a graduate of Jefferson Medical College, Philadelphia, in 1950, and interned at U. S. Naval Hospital, St. Albans, New York.

Ullin W. Leavell, Jr., M. D., has located in Lexington, and will limit his practice to dermatology. A graduate of Duke University School of Medicine in 1945, Dr. Leavell had his training at Duke University Hospital, Durham, and University Hospitals, Cleveland.

Alec Spencer, M. D., West Liberty, has announced the forming of a partnership in his clinic with **Ralph Gullett, M. D.**, also of West Liberty. The clinic will now be known as the Gullett and Spencer Clinic. A new addition of 6 rooms is being added to the Clinic, to be used principally for obstetrics, and will be ready for use about January 1.

The **Henry County Medical Society** held a public meeting Monday evening, November 12, at New Castle. The regular business session of the society was held at the hotel, and then the group adjourned to the courthouse to hear an address by an officer from Fort Knox, who discussed what to do in case an atomic bomb should be dropped in that vicinity. The public was urgently requested to attend the meeting.

Mrs. John S. Harter, Louisville, President of the Woman's Auxiliary to the K.S.M.A., attended the 8th annual conference of presidents and presidents-elect of auxiliaries to state medical societies and committee chairmen of the Woman's Auxiliary to the A.M.A., which was held in Chicago. The conference, built around the theme "Working Together for Health," drew an attendance of more than 150.

Joseph C. Bell, M. D., Louisville, was elected President of the Radiological Society of North America at the annual meeting held in Chicago, December 3-7, 1951. He succeeds **John Bouslog, M. D.**, of Denver, Colorado. Dr. Bell has been a member of the Board of Trustees of the Society, which is the largest organization of its kind, for the past 5 years.

John D. Trawick, Jr., M. D., Louisville, was elected Vice-President of the Southern Psychiatric Association at the annual meeting held in Pinehurst, North Carolina, December 14. Dr. Trawick has been a Fellow of the Association for the past 5 years.

William R. Gabbert, M. D., has located in Danville and will limit his practice to pediatrics. A graduate of Bowman Gray School of Medicine, North Carolina, in 1946, he comes to Danville from Winston-Salem, North Carolina.

E. C. Seeley, M. D., has opened his office in London. Dr. Seeley is a graduate of the University of Louisville School of Medicine in 1947. He was recently discharged from the Navy.

Fred W. den Dulk, M. D., announces the opening of an office in Hyden, Leslie County. He is a graduate of Creighton University School of Medicine, Nebraska, class of 1942.

Albert E. Leggett, M. D., Fincastle Building Louisville, announces his association with his son, **A. E. Leggett, Jr., M. D.**, who will also limit his practice to ophthalmology. Dr. Leggett, Jr., is a graduate of Vanderbilt University School of Medicine in 1945, and served a two-year residency at Wills Hospital, Philadelphia. He has done graduate work at the University of Pennsylvania Graduate School of Medicine.

In Memoriam

JAMES B. MARKEY, M. D.

Hopkinsville

1879 - 1951

Dr. James B. Markey, Hopkinsville, died November 2, 1951, in Paducah. He was born in 1879 in Livingston County, near Birdsville. He was graduated from the University of Louisville Medical Department in 1909. He practiced medicine in Livingston County and later served as staff member and superintendent of Western State Hospital for twenty-five years. He retired from active practice in May, 1951.

RALPH COOK GORE, M. D.

Loan Oak

1874 - 1951

Dr. Randolph Cook Gore, a McCracken County physician, died November 5, 1951. A native of McCracken County, Dr. Gore received his preliminary education at Old Thompson School, near Florence Station. He was graduated from the University of St. Louis School of Medicine in 1898. After graduating he began practicing general medicine under the tutelage of Dr. Frank Boyd and the late D. G. Murrell, Paducah. He was later associated with Dr. W. J. Bass, former city physician of Paducah.

He was hurt in an automobile accident in 1948 but continued practicing medicine from a wheel chair for almost a year. He suffered a stroke which forced him to retire the following year. Throughout his active career he carried

a heavy load of charity patients and was often referred to as "the poor man's friend."

He was a member of the County, State and American Medical Associations.

O. H. ROBERTS, M. D.

Mt. Sterling

1873 - 1951

Dr. O. H. Roberts, Mt. Sterling, died November 6, 1951. He had been in ill health for some time.

Dr. Roberts was born in 1873 in Bath County, and moved to Mt. Sterling about six years ago when he retired after nearly a half century of active practice in Sharpsburg and Bethel.

He was graduated from the Kentucky School of Medicine, Louisville, in 1898.

ALBERT A. DEIG, M. D.

Louisville

1861 - 1951

Dr. Albert A. Deig, Louisville, retired physician and pharmacist, died October 7, 1951. Dr. Deig received his degree in pharmacy from the Louisville College of Pharmacy in 1882 and received his medical degree from the old Louisville Medical College in 1894. He practiced medicine and operated a drugstore at Jackson and Walnut until 1907 when ill health and failing eyesight forced him to give up his practice.

A native of Lanesville, Indiana, he served as a city councilman in 1893 and 1894, and was assistant health officer of that state from 1901 to 1907.

BOOK REVIEWS

ANTIBIOTIC THERAPY: by Henry Welch, Ph.D., Director of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government; Charles N. Lewis, M. D., Medical Officer, Division of Antibiotics, Food and Drug Administration, Federal Security Agency of the United States Government; Published by The Arundel Press, Inc., Washington, D. C., 1951 Price \$10.00.

This book explains all the antimicrobial activity and the pharmacology, the dosage, and clinical use of all available forms of the antibiotics in precise and orderly detail.

It presents a concise, systematic, and clinically oriented guide to the whole field of antibiotic therapy. The available preparations and the susceptible diseases are brought together in specific and concrete detail. Dosage and vehicle of administration are given specific attention. Contraindications, complications, and side reactions are discussed. Alternative forms of therapy are shown but the rationale for each alternative is demonstrated. The danger of the development of resistant strains is discussed in detail.

Thirty-six uniquely effective graphical summaries flash the information in ready to use form. Calculations are eliminated, antimicrobial spectra are pictorially compared, allowances for the individual patient are tailored for the reader in a direct, signposted path from the disease to the prescription.

This book is welcome not only to the specialist, but to the general practitioner because if he is familiar with its contents, he will know how to use scientifically all these new wonder drugs.

BIOLOGICAL ANTAGONISM: The Theory of Biological Relativity; by Gustav J. Martin, Sc. D., Research Director, The National Drug Company, Philadelphia, Pennsylvania. Published by the Blakiston Company, Philadelphia 5, New York 22, Toronto 2. Sixty-four Figures: Forty-four tables. 1951 Price \$8.50.

This is a thorough, complete, yet concise presentation of the theory of biological relativity which underlies all biological activity and is fundamental to the solution of problems in biology.

The author reviews biological antagonism as reflected in natural and synthetic displacing agents, covers antagonism as seen in the fields of amino acids, purines, pyrimidines, vitamins,

hormones, minerals, and as it forms the basis of immunology, pharmacology, and chemotherapy.

Research workers in immunology, pharmacology, chemotherapy, medicine, and the entire field of biology will find the 1,900 references throughout this book extremely helpful. Carefully selected by the author because of their pertinence to the subject, they present a comprehensive survey of all the literature in the field.

STATISTICS FOR MEDICAL STUDENTS AND INVESTIGATORS IN THE CLINICAL AND BIOLOGICAL SCIENCES: by Frederick J. Moore, M. D., Associate Professor of Experimental Medicine; Frank B. Cramer, E. A., Research Fellow; and Robert G. Knowles, M. S., Research Associate, Department of Experimental Medicine, University of Southern California School of Medicine. 11 Figures; 16 tables; 113 pages. Published by The Blakiston Company. 1951 Price \$3.25.

This is a text and reference for medical students, research workers in medicine and the biological sciences, and practitioners who wish to understand and interpret more readily the commonly used statistical forms found in scientific and medical research reports.

It helps them to understand and evaluate statistical findings. It is also a helpful aid in preparing medical research reports.

This book presents in ordinary language the essential mathematical reasoning underlying common statistical procedures. Examples are chosen entirely from the field of medicine and presuppose only the mathematics which the physician or student would acquire naturally in pre-med or medical training.

Each chapter contains tables, illustrative figures, an introduction, and a summary.

ARTHRITIS: by Robert D. Potter, former Science editor of the New York Herald Tribune, Science Service and The American Weekly; Research worker for the Carnegie Institution, Washington; Chairman of the Department of General Science at New York University's School of Commerce and expert consultant in medical administration and writing for the Surgeon General of the Army. Published by Dodd, Mead and Company, New York. 1951 Price \$2.75.

The author of this book served as Executive Director of the Seventh International Congress on Rheumatic Diseases, held in New York in 1949, an outstanding gathering of the world's greatest specialists in the care and treatment of arthritis. This was the time when the great

new discoveries, ACTH and cortisone, were changing so profoundly the whole outlook on arthritis.

The author was given the personal cooperation of all the physicians concerned, to write one inclusive book which a doctor could give to his patient with confidence. The leading physicians in American Rheumatology have read and corrected each individual chapter for its medical accuracy.

The resultant book reviews all of the many principal forms of arthritis and it describes and evaluates the various treatments.

THE PROSTATE GLAND, by Herbert R. Kenyon, M. D., Associate Clinical Professor, Department of Urology, New York University, Bellevue Medical Center. Random House, Publishers, New York. Price \$2.95.

Men in middle life and in old age are confronted with the actuality or the prospect of suffering from any one of the many disabilities and diseases of the prostate gland. In order to give authoritative information and guidance to laymen, Dr. Herbert R. Kenyon, eminent urologist, here clarifies in simple, non-technical language the importance of the male gland which plays so vital a role in sexual activity and reproduction. He explains the diseases it is heir to and the medical and surgical means by which it can be restored to its normal function, rendered harmless, or removed entirely. The medical and surgical procedures are explained, and diagnosis, treatment and prognosis are given with such candor and simplicity that any one who reads can understand.

QUINIDINE in Disorders of the Heart by Harry Gold, M. D., professor of Clinical Pharmacology at Cornell University Medical College, Attending-in-Charge of the cardiovascular Research Unit at the Beth Israel Hospital, Attending Cardiologist at the Hospital for Joint Diseases, Managing Editor of the Cornell Conference on Therapy. Paul B. Hoeber, Inc., Medical Book Department of Harper and Brothers, Publishers, New York City. Price: \$2.00.

This concise manual shows how to obtain maximum therapeutic results from the use of quinidine in disorders of cardiac rhythm. This book takes up each disorder for which quinidine is effective, explains the physiologic mechanism involved, shows the precise therapeutic objective, explains the particular action of quinidine on which reliance is being placed,

points out any dangers which may rise, gives the doses and course of treatment in precise detail, and discusses the toxic effects of quinidine and their control. Particular stress is placed on the rationale of every procedure recommended in the book.

WHEN MINDS GO WRONG, A SIMPLE STORY OF THE MENTALLY ILL, PAST, PRESENT AND FUTURE, by John Maurice Grimes, M. D., twenty years a psychiatrist, four years a staff member of the Council on Medical Education and Hospitals of the American Medical Association, and author of *Institutional Care of Mental Patients in the United States*. First Edition, 237 pages, illustrated. Published and distributed by the author, 5203 South Harper Avenue, Chicago, 15. Price \$5.00.

This is a very valuable book for psychologists, sociologists and social workers and to all associations who are interested in alleviating the misfortune of mental illness. It contains many interesting case reports which include the writer's technique in restoring persons to normal lives. The writer has had unlimited experience as he directed a two year investigation of mental hospitals for the American Medical Association. The price of the book has been reduced to \$5.00 so it can be more widely distributed.

SIR WILLIAM OSLER APHORISMS From his bedside teachings and writings, collected by Robert Bennett Bean, M. D., Edited by William Bennett Bean, M. D., Henry Schuman, Inc., Publishers, 20 East 70th St., New York 21, N. Y., Publishers. Price \$2.50.

The late Sir William Osler was probably one of the best loved and certainly one of the most influential physicians in modern medicine. He was always concerned not only with the specifics of medical research and progress, but with the much broader, humanistic aspects of medical science. And he was exceptionally cosmopolitan and sophisticated, often wryly humorous, in his outlook.

His "Boswell," the late Robert Bennett Bean, jotted down many of Sir William's reflections and observations and also culled a large number of aphorisms from Sir William's writings. These have now all been collected in this volume by Dr. William Bennett Bean, Robert Bean's son. The result is a distillation of Sir William's philosophy and a volume of inspiration and counsel for all interested in medical practice.

1951

CONSTITUTION AND BY-LAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

CONSTITUTION

- Article I. Name of the Association
- Article II. Purpose of the Association
- Article III. Component Societies
- Article IV. Composition of the Association
- Article V. House of Delegates
- Article VI. Sections and District Societies
- Article VII. Sessions and Meetings
- Article VIII. Officers
- Article IX. Funds and Expenses
- Article X. Referendum
- Article XI. The Seal
- Article XII. Amendments

BY-LAWS

- Chapter I. Membership
- Chapter II. Annual and Special Sessions of the Association
- Chapter III. General Meeting
- Chapter IV. House of Delegates
- Chapter V. Election of Officers
- Chapter VI. Duties of Officers
- Chapter VII. The Council
- Chapter VIII. Committees
- Chapter IX. Assessments and Expenditures
- Chapter X. Rules of Conduct
- Chapter XI. Rules of Order
- Chapter XII. County Societies
- Chapter XIII. Amendments

CONSTITUTION

Article I. Name of the Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science, to the elevation of the standard of medical education and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians and to the guarding and fostering of their material interest and to the enlightenment and direction of public opinion in regard to the great problem of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public

in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those county medical societies which hold charters from this Association.

Article IV. Composition of the Association

The Association shall consist of the members of the component societies as defined in the By-Laws.

Article V. House of Delegates

Section 1. The House of Delegates shall be the legislative and business body of the Association.

Section 2. Delegates shall be members of and elected by component societies in accordance with the By-Laws. Officers of the Association and Delegates to the American Medical Association and the five immediate Past-Presidents shall be ex-officio members of the House of Delegates and entitled to vote.

Section 3. The Speaker or Vice-Speaker shall preside during the meetings of the House of Delegates. The Presiding Officer shall not be entitled to a vote except in the event of a tie vote.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VI. Sections and District Societies

The House of Delegates may provide for a division of the scientific work of the Association into appropriate Sections and for the organization of such Councilor District Societies as will promote the best interest of the profession, such societies to be composed exclusively of members of component county societies.

Article VII. Sessions and Meetings

The Association shall hold an annual session and such special sessions as may be desirable in accordance with the By-Laws of the Association.

Article VIII. Officers

Section 1. The Officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, and a Councilor from each Councilor District that may be established and such other Officers as provided for in the By-Laws.

Section 2. The Officers of the Association shall serve for the term of office and subject to provisions as specified in the By-Laws.

Section 3. All Officers shall serve until their successors have been elected and installed.

Section 4. The Officers of the Association shall be elected at the last session of the House of Delegates at the annual session of the Association and shall take office on that day unless otherwise specified.

Article IX. Funds and Expenses

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by an equal per capita assessment upon each county society to be fixed by the House of Delegates by voluntary contribution and from the profits of its publication. Funds may be appropriated by the House of Delegates to defray the expenses of the Annual Session, for publication and for such other purposes as will promote the welfare of the Association and profession.

Article X. Referendum

The General Meeting of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a similar vote of its own members or after a like vote of the General Meeting, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question and be binding upon the House of Delegates.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

BY-LAWS

Chapter I. Membership

Section 1. A member of this Association must be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society,

properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association the name of the member shall be included in the official roster of the Association and the member shall be entitled to all the privileges of his class membership.

Section 2. Active Members. Active members shall comprise the active members of the component medical societies. To be eligible for active membership in any component county society the applicant must be:

A. A doctor of medicine who is licensed to practice medicine in the State of Kentucky and who is of good moral and professional standing.

B. A medical officer of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

C. Any doctor of medicine engaged in scientific or professional pursuits whose principles and ethics are consonant with those of the State Association.

Section 3. Associate Members. Associate members shall consist of associate members of the component medical societies who are not eligible for active membership and who are qualified under one or more of the following groups:

A. An intern, resident or teaching fellow who is a Doctor of Medicine but who is not licensed to practice medicine in the state.

B. A person who is not a Doctor of Medicine but who is engaged in scientific, professional or other pursuits, whose principles and ethics are consonant with those of the Association.

C. A Doctor of Medicine residing and practicing outside the area covered by the component society and who is an active member in good standing in his own component society.

Associate members shall not have the right to vote nor to hold office. The Council shall, from time to time, determine the amount of dues to be charged. Associate members shall receive the Journal and the publications of the Association.

Section 4. Emeritus Members. Component societies may elect as a Member Emeritus any Doctor of Medicine who has retired from active practice and who has previously maintained active membership in good standing in his society. Emeritus members shall not have the right to vote nor to hold office and shall not pay dues. They shall receive the Journal and other publications of the Association.

Section 5. Student Members. Any student in an accredited medical school in Kentucky

or any resident of Kentucky who is a student in an accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The Council shall determine, from time to time, the amount of dues to be charged. Student members shall receive the Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

Section 6. Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent State Medical Association and who has participated in the program of the Scientific Session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privilege on the floor in all scientific sessions.

Section 7. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any annual session upon invitation of the Association or its Council and shall be accorded the privilege of participating in all of the scientific work of that session.

Section 8. The name of a physician upon the properly certified roster of members or list of delegates, of a chartered county society which has paid its annual assessment, shall be prima facie evidence of his right to register at the Annual Session in the respective bodies of this Association.

Section 9. No persons who are under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its rolls of membership shall be entitled to any of the rights or benefits of this Association, nor its proceedings until such time as he has been relieved of such liability.

Section 10. Each member in attendance at the Annual Session shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member or delegate shall take part in any of the proceedings of an annual session until he has complied with the provision of this section.

Chapter II. Annual and Special Sessions of The Association

The Association shall hold an annual session

and such special sessions at such time and place as may be determined by the House of Delegates.

Chapter III. General Meeting

The General Meeting shall include all registered active members, associate members and guests. Associate members and guests shall not have the right to vote on pending questions, but shall have equal rights with active members to participate in the proceedings and discussions. Each General Meeting shall be presided over by the President or in his absence or disability or upon his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the annual orations and the entire time of the sessions as far as may be, shall be devoted to papers and discussions relating to scientific medicine.

Chapter IV. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Session of the Association and shall so fix its hours of meeting as not to conflict with the first General Meeting of the Association, or with the meeting held for the address of the President and the annual orations so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interest of the association and profession require, it may meet in advance or remain in session after the final adjournment of the General Meeting. The House of Delegates may be called into special session by the President with the approval of the Council and a special session of the House of Delegates shall be called by the President on a written request of the delegates representing fifty or more component county societies. When such special session is called the Secretary shall mail a notice of the time and place and purpose of such meeting to the last known address of each member of the House of Delegates at least ten days before such special session.

Section 2. In the event there is no duly authorized delegate in attendance at the regular meeting of the House of Delegates the President shall consult any duly elected officer of the component society who is in attendance and with the approval of the Credentials Committee may appoint any active member of the component society in attendance at the meeting as the delegate. In the event there is no duly elected officer of the component society in attendance, the President may make the said appointment with the approval of the Credentials Committee. All appointments made

shall also be with the approval of the House of Delegates.

Section 3. A majority of the registered delegates shall constitute a quorum and all of the meetings of the House of Delegates shall be open to members of the Association. The House of Delegates shall have the right to go into executive session whenever such action is indicated in the judgment of the House of Delegates, except that active members of the Association shall have the right to attend all executive sessions.

Section 4. From among the members of the House of Delegates the Speaker of the House of Delegates shall appoint a Nominating Committee, a Committee on Credentials, Rules and Order of Business, Report of Officers and the Council, Report of Standing Committees, Report of Special Committees, Report of Advisory Committees, Resolutions, Miscellaneous Business, Revision of By-Laws and Constitution, and such other committees as he may deem necessary, as well as Tellers and Sergeant-At-Arms. All appointments by the Speaker of the House of Delegates are subject to approval by the House of Delegates.

Section 5. Each Resolution introduced into the House of Delegates shall be in writing and presented to the Secretary. Immediately after the Delegate has introduced the Resolution it shall be referred to the proper Reference Committee before action thereon is taken.

Section 6. No new business shall be introduced in the last meeting of the House of Delegates without unanimous consent of the Delegates except when presented by the Council. All new business so presented shall require three-fourths affirmative vote for adoption.

Section 7. It shall, through its officers, Advisory Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Session a stepping stone to further ones of higher interest.

Section 8. It shall consider and advise as to material interest of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

Section 9. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as many be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and

systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who can be made reputable, has been brought under medical society influence.

Section 10. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 11. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

Section 12. It shall upon application provide and issue charters to county societies organized to conform to the spirit of the Constitution and By-Laws.

Section 13. In sparsely settled sections two or more County Societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The County Society thus combined shall not lose any of its privileges and representation. The active members of each County Society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the State Association.

Section 14. It may divide the counties of the State into Councilor Districts, and, when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, to meet midway between the annual sessions of the Association, and members of the chartered county societies and none other shall be members.

Section 15. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 16. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 17. The complete proceedings of the House of Delegates shall be published in the Journal of the Association.

Chapter V. Election of Officers

Section 1. The President-Elect and the Vice Presidents shall be elected for a term of one year. The Speaker and Vice-Speaker of the House of Delegates shall be elected for a term of three years. The Secretary and Treasurer shall be elected for a term of five years. The Councilors shall be elected for a term of three

years and shall be limited to serving for not more than two consecutive terms. The terms shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice-President, Speaker or Vice-Speaker of the House of Delegates or Councilor who has not been an active member of the Association for at least five years.

Section 2. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting continue until an election occurs in like manner.

Section 3. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of this Association shall be ineligible for any office for two years.

Section 4. The election of officers shall be the order of business in the House of Delegates on the last day of the General Session.

Section 5. The Nominating Committee shall nominate candidates for all offices except that of Councilors and shall make its report to the House of Delegates. Additional nominations may then be made from the floor by any member of the House of Delegates.

Section 6. The Delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating a Councilor for the Councilor District concerned. This committee shall hold a meeting open to all active members of Councilor District concerned who are in attendance at the meeting for the purpose of discussing the nomination for the Councilor to serve the District. Additional nominations may be made from the floor by any member of the House of Delegates when the Nominating Committee makes its report to the House of Delegates.

Chapter VI. Duties of Officers

Section 1. The President shall preside at all general meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such other duties as customary and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Councilors in building up the county societies and in making their work more practical and useful.

Section 2. The President-Elect shall be a member of the Committee on Scientific As-

sembly. He shall become President of the Association at the next annual meeting of the Scientific Session following his election as President-Elect. He shall assist the President in visitation of county and other meetings and shall be ex-officio a member of the House of Delegates with the right to vote. In event of death, resignation, or if he becomes permanently disqualified, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at the next annual meeting of the Scientific Session of the Association.

Section 3. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation or removal, the Council shall elect one of the Vice-Presidents to succeed him.

Section 4. The Speaker of the House of Delegates of the Association shall preside at all meetings of the House of Delegates. He shall appoint all committees for the House of Delegates with the approval of the House of Delegates. He shall be an ex-officio member of all said committees. He shall perform such other duties as custom and parliamentary usage may require.

Section 5. The Vice-Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, resignation or removal of the Speaker, the Vice-Speaker shall automatically become Speaker of the House of Delegates.

Section 6. The Treasurer shall give bond for the trust imposed in him whenever the House of Delegates shall deem it requisite. He shall demand and receive all funds due the Association, together with the bequests and donations. He shall, under the direction of the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall in general subject to such direction have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or his Executive Assistant and shall be counter-signed by the Treasurer of the Association. Under unusual circumstances, when one or more of the above named officials are not readily available, the President of the Association or the Chairman of the Council is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Council. The Treasurer shall subject his accounts to an annual audit under the direction of the Council. He shall render

an annual account of his doings and the state of all Association funds.

Section 7. The Secretary, acting with the Committee on Scientific Assembly, shall prepare and issue the program for and attend all meetings of the Association and of the House of Delegates and he shall keep minutes of their respective proceedings in separate record books. He shall charge upon his books the assessments against each component county society at the end of the fiscal year; he shall collect and make proper credits for the same and perform such other duties as may be assigned him. He shall be custodian of all record books and papers belonging to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which may come into his hands. He shall provide for the registration of the members and delegates at the Annual Session. He shall keep a card index register of all practitioners of the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association for publication. In so far as it is in his power he shall use the printed matter, correspondence and influence of his office to aid the Councilors in the organization and improvement of the county societies and in extension of the power and usefulness of this Association. He shall conduct the official correspondence, notify members of meetings, officers of their election, and committees of their appointments and duties. He shall act as secretary of the Committee on Scientific Assembly. He shall be editor of the Kentucky Medical Journal. He shall employ such assistants as may be ordered by the Council or the House of Delegates. He shall annually make a report of his doings to the House of Delegates.

In order that the Secretary may be enabled to give that amount of his time to his duties which will permit of his becoming proficient it is desirable that he shall receive some compensation. The amount of his salary shall be fixed by the House of Delegates.

Chapter VII. The Council

Section 1. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall consist of the duly elected Councilors. The President, the President-Elect, the immediate Past President, the Speaker of the House of Delegates, the Secretary and the Treasurer shall be ex-officio members of the Council with the right to vote. The Executive Committee of the Council shall consist of the President, the

Chairman of the Council, the Secretary, and two Councilors to be elected annually by the Council. The Executive Committee shall exercise the powers of the Council between sessions of the Council and be directly responsible to the Council for all their actions.

Section 2. The Council shall hold daily meetings during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three councilors. It shall meet on the last day of the Annual Session of the Association for reorganization and for the outlining of the work for the ensuing year. At this meeting it shall elect a chairman and secretary and it shall keep a permanent record of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the account of the Secretary and Treasurer and other agents of this Association and shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. In the event of a vacancy in any office the Council may fill the same until the annual election.

Section 3. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his doings, and of the condition of the profession of each county in his district to each Annual Session of the House of Delegates. The necessary traveling expenses incurred by Councilor in the line of his duties herein imposed may be allowed by the House of Delegates upon a proper itemized statement, but this shall not be construed to include his expense in attending the Annual Session of the Association.

Section 4. Collectively the Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates of the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or a county society upon which appeal is taken from the decision of an individual Councilor. Its decision in all such cases shall be final.

Section 5. The Council shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation and other important matters to the public and the lay press. Such communications shall be signed by the President of the Association and the Chairman of the Council as such.

Section 6. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Association and shall have authority to appoint such assistants to the editors as it deems necessary. It shall manage and conduct the Kentucky Medical Journal, which is the organ of the Association, and all money received by the Journal, the Councilor or any officer of the Association, shall be paid to the Treasurer of the Association on the first of each month.

Section 7. All reports on scientific subjects and all scientific discussions and papers read before the Association shall be referred to the Kentucky Medical Journal for publication. The editor, with the consent of the Councilor for the District in which he resides, may curtail or abstract papers or discussions, and the Council may return any paper to its author which it may not consider suitable for publication.

Section 8. All commercial exhibits during the Annual Session shall be within the control and direction of the Council.

Chapter VIII. Committees

Section 1. The Standing Committees shall be as follows:

- A Committee on Arrangements
- A Committee on Scientific Assembly
- A Committee on Public Relations
- A Committee on Medical Service
- A Committee to Study Constitution and By-Laws

A Medico-Legal Committee and such other committees as may be necessary. The Headquarters Office at 620 South Third Street, Louisville 2, Kentucky, shall be the headquarters for all committees and activities of the Association except as may be specifically authorized by the Executive Committee. Committees shall be appointed by the President of the Association in conference with the Secretary unless otherwise specified. The President and the Secretary shall be ex-officio members of all committees except as otherwise specified.

Section 2. The Committee on Arrangements shall consist of as many members and subcommittees as are appointed by the President of the Association. No county medical society as such shall serve as the host society. The Chairman shall report an outline of the arrange-

ments to the Secretary for publication in the program and shall make such announcements from time to time as may be desired. All expenses of the Committee on Arrangements shall be paid out of the funds of the Association that are made available for that purpose.

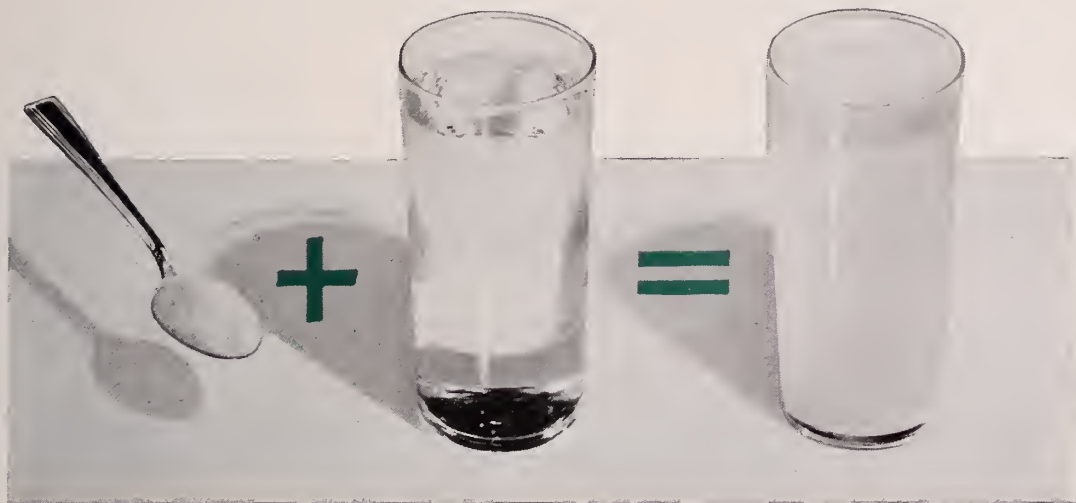
Section 3. The Committee on Scientific Assembly shall consist of five members. The President of the Association shall be a member and Chairman of the Committee. The President-Elect shall be a member of the Committee. The Secretary of the Association shall be a member and Secretary of the Committee. The President of the Association shall appoint one member for a two-year term. The Committee shall determine the character and scope of the scientific proceedings of the Association, subject to the provisions or the instructions of the House of Delegates or of the Association or to the provisions of the Constitution and By-Laws. Thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers, discussions and other business shall be presented which shall be adhered to by the Association as nearly as practicable.

Section 4. The Committee on Public Relations shall consist of five members appointed by the Council of the Association. The members shall be appointed for a term of three years each, which shall be staggered insofar as possible. The Chairman of the Committee shall be designated by the Council. Under the direction of the Council it shall represent the Association in securing and enforcing legislation in the interest of Public Health and scientific medicine. It shall keep in touch with the profession and public opinions, shall endeavor to shape legislation so as to secure the best results for the whole people and shall utilize every organized influence in local, state and national affairs and elections. Its work shall be done with dignity becoming a great profession and with that wisdom which make effective its work and influence. It shall have authority to be heard before the entire Association upon questions of great concern at such times as may be arranged during the annual session.

Section 5. The Committee on Medical Service shall consist of five members appointed by election of the Council. The terms of each member shall be for three years and shall be staggered insofar as possible. The Council shall annually designate the Chairman of the committee. It shall be concerned with and responsible for all matters of Medical Education and Medical Economics which shall be within the province of the State Medical Association. It shall continually strive to serve as a liaison

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between the public and the Medical Association in these matters.

Section 6. The Medico-Legal Committee shall consist of three members, one of whom, the Chairman, shall be elected by the Council for five years, and the Secretary and Treasurer shall be the other two members ex-officio. This Committee shall select and fix the compensation for an attorney, who shall act as general counsel, and if required, additional local counsel. The Association through this Committee shall defend its members who are in good standing against unjust suits for malpractice.

Section 7. The Committee to Study the Constitution and By-Laws shall make a constant study of the Constitution and By-Laws. The committee shall annually make a recommendation concerning changes which it feels should be made in order to keep the Constitution and By-Laws in line with changing conditions and circumstances.

Chapter IX. Assessments and Expenditures

Section 1. The assessment of fifteen dollars per capita on the membership of the component societies is hereby made the annual dues of this Association. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association on the first day of January in each year.

Section 2. Any county society which fails to pay its assessments, or make the report required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have the prior approval of the Council before they can become effective.

Chapter X. Rules of Conduct

The principles set forth in the Principles of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

Chapter XI. Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XII. County Societies

Section 1. All county societies now in affiliation with the State Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one state-wide society of worthy Negro physicians who are not members of any county society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association. When more than one county society exists friendly overtures and concessions shall be made with the aid of the Councilor of the District if necessary and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Section 5. Each county society shall judge of the qualifications of its own members, but as such societies are the only portals to this Association every reputable and legally registered physician who is practicing, or who will agree to practice nonsectarian medicine shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Section 6. Any physician who may feel aggrieved by the action of the society of the county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, which upon a majority vote may permit him to become a member of an adjacent county society.

Section 7. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a

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Board and as individual councilors in district and county work, effort at conciliation and compromise shall precede all such hearings.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

Section 9. A physician living in or near a county line may hold membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Section 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county, and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do post-graduate and original research work, and to give the society the first benefit of such labors. Official position and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers each component society shall elect a delegate or delegates to represent it in the House of Delegates of this Association in the proportion of one delegate to each twenty-five members or major fraction thereof and the secretary of the society shall send a list of such delegates to the Secretary of this

Association on or before April 1 of each year.

Section 13. The Secretary of each county society shall keep a roster of its members and a list of non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each county society shall report to the Kentucky Medical Journal full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

Section 15. County societies may invite Dentists, Pharmacists, Funeral Directors, or other professional persons to become Associate Members of the County Society but such Associate Members shall not have any privileges or representations in the State Association.

Chapter XIII. Amendments

These By-Laws may be amended by any Annual Session by a two-thirds vote of all the delegates present at that session, after the amendment has been laid on the table for one day.

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Present Trends in Colon Surgery

ARTHUR W. ALLEN, M. D.*

Boston, Mass.

Up to a decade ago, the mortality rate following resection of the large bowel averaged approximately 10% in the hands of the most skilled surgeons. This was not out of keeping with the hazards in all major surgical procedures, although in many situations of similar magnitude, the mortality rate was lower. For the past twenty years there has been a steady advancement brought about by a gradual development of surgical technique and practices. The advantages of a better understanding of the physiologic needs of the body leading to more careful preparation of the patient for surgery, better anesthesia, more accurate attention to blood replacement, and to chemical and fluid balance, as well as proper after-care, led to this improvement.

Value of Antibiotics

It is interesting that with the advent of chemotherapy, and particularly antibiotics, that there was a spectacular reduction in morbidity and mortality in all surgical procedures. Resection of the colon shared in this happier situation more than surgery in many parts of the body. This, we believe, is due to the bacterial flora of the large bowel, which has always been difficult to keep under surgical control. The pre-operative oral use of sulfathaladine and sulfasuxidine as well as streptomycin, and aureomycin, undoubtedly renders the intestinal contents less virulent. Therefore, failure due to peritonitis, the chief cause of previous concern, has been practically eliminated.

These improvements have increased the scope of surgery of the bowel materially. Elderly patients with extensive lesions that have spread to other regional areas, can now be safely operated upon with hope of cure in a large percentage of cases. Many of these patients prior to this past decade, were considered incurable and non-resectable. With the increasing age of the average patient now seen, we are constantly aware of the advances in surgery that make it possible for these individuals to recover from long and extensive operations.

Public Should Be Educated

There has been a constant effort on the part of the profession to educate the public concerning early signs and symptoms of malignant disease. In a report made by us in 1943, we found that the average delay from onset of symptoms to appearance in the hospital of colon cancer patients was seven months. We now find that in our more recent cases, patients are appearing with an average duration of symptoms of 4.5 months. Since we are all aware of the advantages of early diagnosis and early surgery, from the standpoint of eventual cure, we should continue our educational efforts along these lines. It is quite possible that in another decade patients will go to their physician at the first sign of any change in bowel habit or when blood in the stool is noticed. This will materially increase the cure-rate in this disease. It is admitted that a small proportion of patients appear in an almost hopeless situation without any previous symptoms that they will admit. This situation, fortunately, is rare, and probably cannot be avoided. There is another group of patients who come

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Read before the Kentucky Surgical Society, French Lick Springs, Indiana, May 19, 1951.

with a fairly small lesion in the bowel with negative lymph nodes, but with blood stream metastasis direct to the liver. This, we believe, may take place in about 20% of the cancers of the large bowel that we see, and at the moment there seems to be no way to make a diagnosis in this group in the remediable stage.

Early Symptoms Important

Every physician should be alert to the early symptoms of cancer of the bowel. A patient who has had regular movements without difficulty most of his life, and suddenly develops a change in his bowel habits, whether it be increased constipation or increased looseness, should be thoroughly investigated. All patients who come to a physician complaining of bleeding with stools, must be carefully studied. We must not assume that this bleeding comes from hemorrhoids but must prove that this is the source.

Thorough Examination Necessary

The examination of a patient who comes with such symptoms must be carried out in a logical manner. First of all, a careful history, including that of his family, must be made. Symptoms of fatigue, based on anemia, are frequently associated with lesions of the right colon. Abdominal palpation and auscultation will sometimes pay big dividends. Increased peristalsis may be heard and one may feel a mass in a curable case, or the patient himself may have discovered a mass, and call the doctor's attention to it. This is particularly true of lesions of the right and transverse colons. A rectal examination must be done with great care. It is helpful to have the patient in Sims' position, and when the index finger is gently inserted into the rectum, when he strains down, one may feel tumors quite high that are brought down against the examining finger. The patient should then be put in lithotomy position and a bimanual examination done. Lesions in the sigmoid can often be outlined by this simple maneuver. Having done this, the patient should be sigmoidoscoped, and if the physician is not equipped to carry out this examination himself, the patient should be referred to a qualified colleague. Sigmoidoscopy will reveal lesions as high as the length of the scope, 26 cm. If no disease is found below this level, one may see bloody mucus coming from above this point, which gives a clue to the diagnosis. After sigmoidoscopy, even if the source

of trouble is found, and is not obstructing, the patient should then be referred for a barium enema. This should rule out other lesions in the colon such as polyps, or reveal a tumor beyond the range of the sigmoidoscope.

Dangers of Preliminary X-Ray Examination

Under no circumstances should the patient be referred for x-ray examination as a preliminary course of study in a suspected carcinoma of the bowel. In the first place, a very high percentage of the lesions are within the range of the sigmoidoscope, or even in the range of the examining finger. A better reason, however, is that if there is a partially obstructing cancer from above, and the roentgenologist is unaware of this possibility, he may unwittingly, fill the entire colon with barium and precipitate an extremely hazardous situation. Many of these tumors have a valve-like action in one direction or the other. The patient, completely obstructed from a growth in an isoperistaltic direction may have barium introduced from below through such a tumor without difficulty. It is best for the physician and the roentgenologist to confer concerning their suspicions before this examination is made. In a patient with acute large bowel obstruction, one may locate the point of obstruction by the gas-pattern in a scout film alone. This having been done, and the roentgenologist understanding it, it can be confirmed by a carefully-given small barium enema without risk. It should go without saying that patients suspected of large bowel lesions should never receive a barium meal by mouth until the colon has been cleared of suspicion by the examinations outlined above.

Operative Procedures

Having made the diagnosis of cancer of the large bowel, the patient should then be carefully prepared in the hospital for surgery. If he is completely obstructed, or nearly so, it may be necessary to do a preliminary decompression of the bowel. In right-sided lesions that are obstructing, this is best done by a preliminary ileo-transverse colostomy in continuity. In the left-sided tumors, a preliminary tube cecostomy is usually best. This gets the patient over the immediate hazard of acute obstruction, and can be followed in a few days by complete transverse colostomy in very ill and completely ob-

structed patients. It may take, on occasion, three weeks to get a patient in shape for his definitive procedure.

Preliminary Preparation of Patient

Fortunately, most of the patients are not obstructed and can be prepared for resection within a week after the diagnosis has been made. These patients are usually elderly, and should be carefully evaluated from the standpoint of their heart, kidneys, and blood picture, etc. Blood chemistry should include a prothrombin time since venous thrombosis is more common in all individuals with degenerative diseases. Sulfathaladine in divided doses, 8 grams per day, for five days, usually suffices to cleanse the bowel in a non-obstructed patient, and lower the virulence of the bacterial flora. To this may be added 1 gm. of streptomycin by mouth twice a day for forty-eight hours prior to operation. The same effect may be had with daily doses of 750 mgm. of aureomycin, although at this time we feel that patients prepared with this drug do not have as clean a bowel with which to work as do those who can be given sulfathaladine.

In patients who are not obstructed, that have large fecal deposits in the colon proximal to the growth, one may begin the preparation to advantage by a large dose of compound licorice powder. This, we think, superior to castor oil or to saline cathartics. We do not believe that cathartics alone is as good or as safe a method of preparation for colon surgery as the chemo-therapeutic measures outlined above.

While this is going on, the patient may receive transfusions to bring his blood picture to within normal range; digitalis or a substitute, as ordered by the cardiologist, if needed; a high caloric low residue diet, etc.

Choice of Anesthesia

The anesthesia in patients for colon surgery may be a matter of choice depending on the skill of the anesthetist available. Spinal anesthesia is perfect, from the standpoint of the surgeon, since it gives muscular relaxation and diminished calibre of the small bowel during the procedure. A well administered gas-oxygen-ether mixture in a closed machine through an intra-tracheal tube, is completely satisfactory and often is the method of choice. It may be important not to give multiple

anesthetic or pre-anesthetic drugs, since there is a definite possibility that the multiplicity of such agents may have a bearing on cardiac arrest.

Type of Incision

The type of incision used may vary considerably. We have found that long paramedian incisions serve well in the right and left colon resections. Transverse incisions are adequate and excellent for tumors of the transverse colon. Long oblique incisions retracting the rectus muscle mesially, are satisfactory for lesions in the sigmoid. One can tell by preliminary x-ray films, the height of the splenic flexure, and must bear this in mind in dealing with the left colon, since on many occasions it is necessary to step down the splenic flexure in order to do an adequate resection.

Exteriorization Operations

Exteriorization operations, first advocated by Bloch, and later by Paul, and still later by Mikulicz, and finally perfected by Rankin, have been extremely popular throughout the world and this attack has been spectacularly successful in the hands of a great many surgeons. There is no criticism on our part regarding this type of procedure, but it appears now to be well out-moded in favor of direct anastomosis. Experience at the Massachusetts General Hospital has been almost entirely with primary anastomosis and the exteriorization operations have been rarely practiced in this clinic. Now, with the better preparation of the bowel, there seems to be less reason to advocate the Bloch-Paul-Mikulicz type of resection.

Operative Procedures

After exposing the field, one must determine as far as possible, the extent of the disease process. Under no circumstances should a tumor of the bowel, even though it may be small or of questionable malignancy, be treated by anything less than a block resection with the entire V-shaped vascular bed draining that area, since the lymph node distribution follows closely the blood vessels. If one finds that the lymph nodes at the apex of the vascular bed from a given lesion appear to be involved, the surgeon should then determine whether or not he may get above the metastatic nodes by including in the resection two or more segments of the bowel. It is not at all uncommon now

to feel that a more curative operation may be accomplished by removing the entire left colon with its blood supply, making the anastomosis between the transverse colon and the recto-sigmoid.

Lesions that have encroached upon other organs must be evaluated and every effort made to remove these structures even if the contact appears to be inflammatory. The female pelvic organs, the bladder, segments of the ureter, the small intestine, the abdominal wall, duodenum, stomach, pancreas, diaphragm, cecum, kidney, seminal vesicles, and liver, have all been included in some of our resections, as well as the spleen and the gall bladder. We have not included an entire lobe of the liver, nor have we removed multiple small metastatic areas in the liver except for confirmation of the diagnosis.

Value and Description of Open Anastomosis

We previously preferred an aseptic anastomosis between the ends of the bowel after the method of Parker and Kerr, and at one time felt that we could reduce the operative mortality by this technique. In the past eight years, however, we have gradually returned to open anastomosis and feel that we can use this method safely in our properly prepared patients. If we find the bowel still full of fecal matter at the time of resection, or in the presence of obstruction in the right colon for our ileo-transverse colostomies, we still use an aseptic basting-stitch technique. We are careful to determine that the ends of the bowel to be anastomosed, have adequate blood supply, and that they can be brought together without any tension whatsoever, before proceeding with the anastomosis.

The segment of bowel to be eliminated having been removed by actual cautery over thin-bladed clamps, allows us to place the posterior row of "quilting cotton" sutures before the clamps are removed. After this is done, and the wound carefully walled off, the clamps are removed and an inner row of double or triple zero chromic catgut is placed posteriorly, in a simple over and over manner, then we invert the mucosa anteriorly with a Connell type of suture. After this is accomplished, the anterior row of cotton sutures are then introduced. These non-absorbable sutures are interrupted and, on the posterior segment, are placed transverse-ly to the linear direction of the bowel.

Eight or ten are needed on this row. The anterior row between the white lines can be vertical stitches, and at the transverse lines, should be transverse, since here there is lack of tensile strength in the linear direction.

Prevention of Soiling

Soiling is prevented by small moist pledgets of gauze, and all instruments, drapes, and gloves are discarded after the anastomosis is completed. With fresh gloves, and fresh instruments and fresh drapes, one then proceeds to close the rent in the mesentery. This is done with a continuous row of fine chromic catgut on an atraumatic needle in such a manner as to invert as far as possible the cut fatty edge. This eliminates to a large extent the hazard of small bowel obstruction. The small intestine has a great affinity for raw surfaces and will attach itself particularly to traumatized fat with great ease.

Disposal of Outer Gutter

The outer gutter either on the right or the left side is usually left open entirely, since it is rarely possible to do a good cancer operation and successfully close this area. Furthermore, there is apt to be a certain amount of ooze from this retro-peritoneal surface which, if left imprisoned, may cause trouble, but if it is allowed to seep into the general peritoneal cavity, is taken care of adequately by natural resources.

Closure of Abdominal Wounds

We have laid considerable stress on making and closing our abdominal wounds. The peritoneum can be closed with continuous zero chromic catgut without difficulty, but the fascia should be sutured with non-absorbable material. We have used cotton for this a great deal. Number 30, ordinary cotton is satisfactory, or the same "quilting" cotton that is used in the anastomosis is adequate in the fascia. For the past year we have used multiple-strand fine wire called "surgaloy" which has as much tensile strength as single-strand wire, but is much more pliable. This material handles almost as easily as silk or cotton and the ends do not have a tendency to tear the gloves as does a single-strand wire. We introduce through the skin, fat, and fascia, at intervals of 1½ cm., heavy button and carpet cotton, and leave these untied. The fat is loosely packed with gauze. Forty-

eight hours later this gauze is saturated with 2% novocaine, and 10 mgm. of morphine is given intravenously to the patient. In ten minutes this gauze can then be lifted out and the sutures tied, without discomfort. These wounds heal as well as primarily sutured wounds, and have resulted in less than 1% of wound infection following colon resection.

Value of After Care

Emphasis is stressed on after-care. The patient's fluid and chemical needs are carefully evaluated according to age, condition, etc. The average patient having undergone colon resection, will require about 2500 cc. of 5% glucose in water, approximately 40 milli-equivalents of potassium, and normal saline volume for volume to replace losses through gastro-intestinal suction. This is administered by the intravenous route, and vitamins are added to the solutions. We have a nasal catheter in the stomach on suction for at least forty-eight hours, to get rid, mainly, of swallowed air. This prevents abdominal distention until normal peristalsis occurs, and also eliminates vomiting. Constant bladder tidal drainage is established routinely for a period of four or five days to eliminate frequent catheterization and distention of the bladder. Transfusions are added, if needed, although most of these people, having received a sufficient quantity of blood prior to surgery and during the operation, do not need subsequent transfusions. We give intramuscularly a mixture of 100,000 units of penicillin, and 0.25 grams of dihydro-streptomycin every four to six hours. This is carried on until all danger of pneumonitis, cystitis, and infection in the operative wound is unlikely, usually six to eight days, although the streptomycin may be omitted after the fourth day. We never continue antibiotics until time of discharge, since it is best to omit them at least four to five days previously, so that if infection is being masked, it will present itself before the patient goes home. The foot of the bed is elevated on six-inch blocks, in order to keep the veins of the legs empty, and the legs are encased in elastic bandages routinely. Deep breathing exercises are carried out periodically. The patient is helped out of bed, usually by the second day, two or three times a day, and assisted to walk around the bed but not allowed to sit in a chair until he is able to get up and move about of his own accord. It is im-

portant to have the patient wear his usual shoes with heels during these walking exercises, to prevent muscle tenderness in the calf, often produced by using bedroom slippers. Many simple cases will be able to go home by the twelfth post-operative day, but due to the distance from which they come, and their home conditions, some may stay as long as eighteen days.

Operations Divided Into Three Categories

We divide our operations into three categories: (1) resections for cure, when all obvious disease has been eliminated; (2) resections for palliation, which are done in the presence of liver metastasis and sometimes when invasion of lymph nodes are so extensive that a cure cannot be expected; (3) those cases that are considered beyond the bounds of resection.

Table I shows the operative mortality associated with these various procedures. Even when contact organs are removed, the mortality rate for resections for cure is very low. This is due to the fact that these patients are less depleted and better operative risks than those with disease that is out of bounds. The two deaths in the resections for cure were from vascular accidents, and not related directly to the operative site.

Table I
CARCINOMA OF THE COLON
1943-May, 1951

	No. of Cases	Deaths	Mortality
Resections:			
For Cure	181	2	1.1%
Palliative	34	4	11.7%
Nonresectable	10	3	30.0%
Total	225	9	4.0%

Palliative Resections

One may question the advisability of doing palliative resections, and at times we have been disappointed in the results obtained. A respite of thirty-seven months, however, is well worth-while. We also believe that resection of the primary focus with anastomosis is the best palliative operation that can be done. As seen in Table II, the average length of sur-

vival in those subjected to palliative resection was ten months.

Table II

RESULTS OF PALLIATIVE RESECTION

1943 to May 1, 1951

34 Cases

Shortest Survival	1 month	Local spread from sigmoid
Longest Survival	37 months	Liver metastasis from sigmoid
Average Survival	10 months	21 cases
Died in hospital:	4	

Table III

RESULTS OF RESECTION FOR CURE

1940-1944

73 cases surviving operation

Shortest Survival	2 months
Longest Survival	11 years
Five-Year Survival	63.0%

Survival Rate

It was hoped that by a higher resectability rate which in this series of 225 patients, being 95.6, plus a low operative mortality, would definitely be reflected in the five-year survival rate. As seen in Table III, we have 73 cases with an average five-year survival rate of 63%. This is too small a series to be of statistical significance, but it is about 20% higher than the five-year survival rate in a previous group of patients studied. It may be that the final result on the entire group of patients will not give us such an optimistic picture, but we do believe that it will be better than it was in our previous series.

It must be borne in mind that this represents a group of private patients which may, on the whole, be better risks than the average general hospital population. It should be noted, however, that the operative mortality for cancer of the colon resections for cure in the general hospital for the past few years is only 3%. Since the majority of these ward cases are done by the resident staff, it is indicative of the present trend in the safety factors re-

garding surgery in general.

President Imes, Louisville: We are all grateful to Dr. Allen for his splendid presentation and interesting movie. There will be no discussion of this paper but I am sure Dr. Allen will be glad to answer any questions you may ask.

Q. M. J. Henry, M. D., Louisville: Dr. Allen, why do you prefer sulfathaladine to sulfasuxidine?

A. A. W. Allen, M. D., Boston: Sulfasuxidine gives more liquid stool and therefore makes the bowel a little more hazardous to handle at the time of the anastomosis. Also, I believe the sulfasuxidine tends to cause bleeding from the growth.

Q. G. B. Sanders, M. D., Louisville: Dr. Allen, do you always use two layers of sutures in your anastomosis? If you do a proximal colostomy do you still use two layers of sutures?

A. I usually do but it is not imperative. I use the inside suture mainly for hemostasis, as practically all of our patients are treated with dicoumarol. I believe even Dr. Harvey Stone with the Halsted technic uses a row of catgut inside.

Q. C. M. Edelen, M. D., Louisville: Dr. Allen, do you use antibiotics before operation other than thaladine?

A. Yes, we give our patients 0.5 gms. streptomycin two times a day per os for forty-eight hours.

Q. J. E. Hamilton, M. D., Louisville: Dr. Allen, what do you do about proximal decompression in primary resections?

A. I do not do this unless there is obstruction, then if there is obstruction I do a cecostomy if the growth is left sided and occasionally do a transverse colostomy. Sometimes it is necessary to wait three weeks for good decompression after the colostomy. If the growth is on the right side with obstruction, of course obstruction is rare on the right side, I do an ileo-transverse colostomy, closed method and resection of the right colon eight to ten days later depending on the condition of the patient. I do not do any decompression if there is no obstruction. We do use the ordinary gastric suction tube which though it has no effect in the obstructed colon does relieve the patient of swallowed air and therefore eliminates "gas pains."

Carcinoma of the Thyroid Gland

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Thyroid carcinoma arises most frequently in nodular goiter. Except for the rare case of the microscopic diagnosis of carcinoma in hyperplastic glands, it is now quite generally accepted that the origin of cancer of the thyroid is, for practical purposes, in the preexisting adenoma of the gland. Thus the small solitary adenoma can be more serious than the large colloid goiter. The size of the nodular goiter is no index to the presence or absence of malignancy.

Incidence

Physicians often state that 5 to 10 per cent of non-toxic nodular goiters are malignant. This, however, does not reflect the true incidence of cancer of the thyroid in this condition. The figures should be broken down further to show whether the original nodular goiter is the discrete, fetal, embryonal adenoma, or multiple colloid adenomatous goiter. The true adenomas are tumors of the thyroid gland, while the multiple colloid adenomatous goiter is really a degenerative disease. All series of cases reviewed show that the incidence of malignancy is much higher in the true adenoma group. In Crile's⁷ series he found 24 cancers in 98 cases of solitary adenomas of the thyroid or 24.5 per cent. Lahey and Hare¹² operated on 1,971 patients with a single nodule in the thyroid gland. In this series 198 or 10.04 per cent were malignant. There were 1,782 patients with multiple nodules operated on and only 11 cancers found or 0.62 per cent malignancy rate. Other series in the literature are as follows: Robertson Ward¹⁹ reported an incidence of 4.8 per cent malignant tumors arising in nodular goiter; Hinton and Lord¹⁰ found the incidence of carcinoma to be 7.6 per cent in clinically benign nodular goiter.

Cole, Slaughter and Rossiter⁵ reported an incidence of 7.2 per cent cancer in nodular goiter. A review at the Massachusetts General Hospital showed the incidence of cancer in nodular goiters to be 3.2 per cent, whereas if only anatomically diagnosed fetal and papillary cystadenoma

were considered, the incidence of cancer would become 11.4 per cent.

Thus early removal of all nodular goiters should be a must in the consideration of carcinoma of the thyroid, and especially is this true of the discrete adenomas. As mentioned above these adenomas are true tumors, and it must be assumed that they will not disappear, but will eventually increase in size. Thus their presence in the body presents a constant danger of cancerous change in them. Therefore, as Dr. Lahey¹² has advised "the smaller the adenoma the greater the reason for removal."

About 25 years ago Dr. Allen Graham⁹ recognized two main types of thyroid carcinomas, the papillary and non-papillary. At this time he named the non-papillary tumors "malignant adenomas." All such tumors, whether highly differentiated angio-invasive adenomas or undifferentiated carcinomas, he classified as malignant adenomas, a term which was misunderstood because the word "adenoma" implied a benign lesion. This led to much confusion. Therefore, Crile⁷ has modified Graham's classification renaming the malignant adenoma "non-papillary carcinoma." This modified classification of Dr. Graham's is as follows:

Carcinoma.

1. Papillary carcinoma.
2. Non-papillary carcinoma (malignant adenoma)
 - (a) Angio-invasive adenoma.
 - (b) Adenocarcinoma.
 - (c) Undifferentiated carcinoma.
3. Special types.
 - (a) Non-encapsulated sclerosing tumor.
 - (b) Squamous cell carcinoma.
 - (c) Metastatic carcinoma.

Sarcoma

1. Lymphoma.
2. Spindle cell sarcoma.

The papillary carcinomas generally metastasize to lymph nodes, whereas the non-papillary carcinomas invade the walls of blood vessels and metastasize chiefly through the blood stream. Papillary tumors occur frequently in children and young adults, while non-papillary tumors follow more closely the general age dis-

tribution of most other carcinomas. Papillary carcinomas carry a much more favorable prognosis than non-papillary carcinomas. Even when there is extensive metastasis to regional lymph nodes, cures usually are obtained by removal of the tumor and the metastatic nodules. When non-papillary tumors metastasize to lymph nodes the prognosis usually is hopeless.

Criteria of Malignancy

The structural and biologic characteristics of malignant tumors of the thyroid gland vary greatly. One of the most characteristic features of such tumors is the high percentage of instances of low grade malignancy. Graham,⁹ after careful study of a large series of cases, concluded that vascular invasion constitutes an absolute and, in some cases in which incapsulated nodules are present, the only criteria of malignancy. Although, many pathologists experienced in this field of study are agreed that vascular invasion is not necessary to the histopathologic diagnosis of cancer of the thyroid. These men rely on anaplasia or cellular differentiation.

Signs and Symptoms

Patients with malignant lesions of the thyroid gland in the late stages are comparatively easy to diagnose correctly. In these individuals the gland is usually nodular, firmly fixed, and the normal contour of the gland is lost. This state of malignant change in the thyroid has to be differentiated from late stages of chronic thyroiditis. It should be remembered that when thyroiditis becomes chronic, there is a stony hard symmetrical enlargement of both lobes of the thyroid gland, but the normal contour of the gland remains intact.

In early cases of carcinoma of the thyroid it becomes increasingly difficult to arrive at a correct diagnosis, since early malignant tumor of the thyroid gland manifests no signs or symptoms. As the disease progresses and before the lesion becomes inoperable, many observations can be made which may lead to a tentative, if not absolute, diagnosis. A history of recent increase in size of a preexisting adenoma, the recent development of a tumor of the thyroid gland, the complaint by the patient of a sense of pressure in the neck, often out of proportion to the size of the tumor, and the finding on palpation of a tumor of the thyroid gland

that is firmer, more nodular and relatively more firmly fixed than that usually encountered in benign goiters, are all suggestive evidence.

Definite limitation of motion and increased firmness of a tumor are manifestations of invasion through the thyroid capsule. However, in cases in which penetration by the cancer is limited to the posterior and mesial aspects of the gland, palpation may reveal no change in its mobility, or consistency to suggest malignant change. In this location a tumor easily could be missed in the course of performance of the usual subtotal thyroidectomy. However, in many cases of posterior invasion by a tumor the inferior laryngeal nerve may be encroached on, occasionally without actual invasion, and the condition becomes manifest by the patient's hoarse, brassy voice, together with fixation of the vocal cord. Thus, irrespective of the size, contour, or consistency of a tumor of the thyroid gland, hoarseness and a fixed vocal cord, in the absence of syphilis, aortic aneurysm, or mitral stenosis, are almost pathognomonic of malignancy. The most common symptoms of which patients complained were referable to pressure caused by enlargement of the tumor, but 18 per cent of the patients reported by Crile and Crile, Jr.,⁶ complained chiefly of systemic symptoms, such as nervousness, weight loss, fatigue or palpitation. Basal metabolic rates are of no value as an aid in differentiation between benign and malignant tumors.

Treatment

The inaccuracy of a clinical diagnosis based on palpation of a thyroid "lump" plus the incidence of carcinoma in clinically benign adenomas points to the desirability of early and complete removal by surgical means of each and every nodule of the thyroid.

Evidence of hyperthyroidism associated with one or more nodules requires careful evaluation, including basal metabolic rates, followed by adequate preoperative control with iodine or propylthiouracil. It is the general feeling that Lugol's solution may be used with complete satisfaction in the majority of cases, whereas the use of propylthiouracil is reserved for those in whom the thyrotoxicosis is unusually severe or in whom an iodine fast state exists. A roentgenogram of the chest, including the cervical region, should be made in every case to rule out

substernal growths and deviation of the trachea. Indirect visualization of the vocal cords should be carried out routinely since an unsuspected unilateral cord palsy is occasionally found.

The choice of anesthesia is a much debated question. Some writers prefer local or regional anesthesia, others intratracheal technic of general anesthesia, while still a third group employ a combination of the two. The main advantages of regional anesthesia are: (1) It decreases the operative time because of the hemostatic effect incident to the block, and (2) It permits immediate appraisal of the integrity of the recurrent laryngeal nerves at the time of the surgical removal of one or both lobes of the thyroid. The indications and advantages of general anesthesia with the intratracheal technic are: (1) It establishes a patent, unobstructed airway, particularly for the removal of the markedly enlarged substernal or retrotracheal glands, and (2) its use may be required because of the nervousness, irritability and apprehension of the patient. Dr. Lahey¹² et al prefer the use of intratracheal general anesthesia. R. J. Coffey⁴ et al combine the two methods. It is their policy to start under superficial cervical block, reserving the use of general anesthesia for these steps in which the gland is being mobilized and manipulated, with resulting pull on the trachea.

The most essential step in an adequate operation for carcinoma of the thyroid is good exposure. This is best accomplished by a generous collar incision, dividing the platysma muscle and wide mobilization of the upper and lower flaps. The upper flap should be freed well above the thyroid cartilage. The cervical fascia is divided in the midline by a generous vertical incision, and the sternohyoid and sternothyroid muscles dissected from both lobes of the thyroid, then divided between clamps.

The type of operation carried out varies somewhat depending on the type, pathological grade and clinical stage of the tumor. Lahey¹² et al advise local excision of the discrete adenoma and leaving as much of the lobe of the thyroid on the affected side as possible.

They then await the report of the microscopic examination of paraffin sections before deciding for or against radical neck dissection. This decision is made by the grade of the tumor. If the tumor is re-

ported to be a papillary adenocarcinoma in a discrete adenoma with no erosion of the capsule and no invasion of the blood vessels or lymphatics radical neck dissection is not indicated. On the other hand radical dissections of the neck are indicated in grade II or grade III tumors. Coffey⁴ et al believe that on encountering a solitary nodule or multiple nodules confined to one lobe, a total lobectomy on the involved side plus removal of the isthmus should be done. B. Marden Black³ recommends total lobectomy for carcinoma limited to one lobe. In carcinoma involving both lobes the total removal of the lobe on the more involved side, the isthmus and a subtotal resection of the less involved lobe is recommended. For carcinoma infiltrated beyond the capsule of the thyroid when some mobility still remains, suggesting that invasion has occurred in a limited region, surgical exploration is indicated since the carcinoma may be removable completely or possibly may be removable except for small masses which can be treated by the local application of radium or radon seeds.

The consensus of opinion, however, seems to be that in all cases of discrete adenoma, a lobectomy, on the involved side, with removal of the isthmus should be performed. If bilateral lesions are present, a subtotal thyroidectomy should be carried out.

If the diagnosis of malignancy in a discrete adenoma is made at the time of operation a total lobectomy on the involved side with removal of the isthmus should be performed to be followed up with post-operative radiation therapy.

In advanced cases of carcinoma total thyroidectomy should be attempted and as much malignant tissue removed as possible. A prophylactic tracheotomy should accompany this procedure and the tube kept in place for several weeks after radiation therapy has been completed.

It has been hoped that with the use of radioactive iodine, metastatic carcinoma of the thyroid would be greatly benefited. But it has been determined that the use of radioactive iodine is limited because many of the malignant cells of thyroid cancer will not take up I-131 and thereby avoid destruction. The iodine uptake of malignant thyroid tumors can be materially improved by total thyroidectomy. Thus, when secondary lesions are present that are being treated by this method, it is advisable to do a total thyroidectomy be-

fore treatment with radioactive iodine is begun.

Report of Cases

Case 1. Mrs. O. E., 5412, 33-year-old white female, who first noticed a goiter 14 years ago. It did not give her any trouble until six months previous to admission to hospital, at which time she began to notice "smothering spells," increased nervousness and weight loss. In spite of a good appetite has lost 42 pounds in past six months. During this time there has been marked increase in the size of the goiter.

PHYSICAL EXAMINATION: Temperature 99, pulse 90, respiration 20, blood pressure 130/85. General physical examination essentially negative except for a large tumor mass in right side of neck which measured approximately 7 cm. by 7 cm. This mass was soft, smooth and freely movable. Vocal cords were normal to laryngoscopic examination. Laboratory examination: urinalysis negative, R. B. C. 3,950,00, hemoglobin 11.4 grams, W. B. C. 7,950, polynuclears 66%, lymphs 34%, eosinophiles 2%, stabs 4%, Kahn was negative. X-ray of chest and cervical region showed deviation of the trachea toward the left, and a widening of the superior mediastinum, which was thought to be a substernal thyroid.

Basal metabolism rate on admission to the hospital was plus 74. She was placed on Lugol's and Phenobarbital. Two days later B. M. R. had fallen to plus 65. One week of the above medication lowered the B. M. R. to plus 32. Also by this time the pulse rate had fallen to 70. It was thought that she was in satisfactory condition for surgery so eight days following admission to the hospital she was operated on under intratracheal general anesthesia. A right lobectomy with removal of the isthmus was done. Patient made an uneventful recovery from the operation.

PATHOLOGY REPORT: Gross: The specimen consists of a large encapsulated tumor, measuring 7 x 6 x 5 cms. from thyroid. The tissue cuts with little resistance, and the surface of the cut section is reddish-brown in color, and is definitely opaque. There are some areas that show evidence of degeneration.

HISTOPATHOLOGY: The sections show a fetal adenoma which, in some areas, shows rather pronounced hyperplasia. The nuclei are large, and adjacent to the connective tissue bands the cells are quite

suggestive of early carcinoma.

DIAGNOSIS: Large fetal adenoma with areas showing pre-cancerous hyperplasia.

This patient has now been operated on six months and when seen two weeks ago she was in excellent health. The toxic symptoms had cleared up and there was no sign of local recurrence.

Case 2. Mrs. J. L., 146717, 23-year-old white female who was first seen 3 years ago. At that time she was admitted to the hospital for treatment of a non-toxic adenoma in the left lobe of the thyroid; was operated on and the adenoma was excised. At the time of operation the remaining thyroid tissue looked and felt entirely normal. Patient made an uneventful recovery and was discharged from the hospital on the fifth postoperative day.

PATHOLOGY REPORT: Gross: Specimen consists of a portion of the thyroid tissue 6 x 3 x 2 cms. The surface is smooth. The cut surface shows very large acini filled with colloid.

HISTOPATHOLOGY: Section shows many dilated gland acini completely filled with colloid and lined with a very flattened epithelium. There is very little stroma.

DIAGNOSIS: Colloid adenoma.

She was followed at intervals for a period of one year with no signs of recurrence. In February of 1951 she reappeared with a nodule in the right side of the thyroid gland. Since last seen she had gotten married and had one child. The mass in her neck was first noticed soon after delivery of her baby 7 months ago, and has grown quite rapidly since. There were no symptoms of toxicity.

PHYSICAL EXAMINATION: Temperature 98.6, pulse 80, respiration 20, and blood pressure 120/80. General physical examination was essentially negative except for a firm, slightly irregular and rather fixed mass in the right lobe of the thyroid which measured approximately 1.5 cm. by 1.5 cm. Vocal cords were normal on laryngoscopic examination. X-ray of chest and cervical region showed the lungs to be clear and no displacement of the trachea. Blood count and urinalysis were both essentially normal. B. M. R. was plus 6. She was prepared with Lugol's solution for one week and then taken to surgery. At this time a total right lobectomy with removal of the isthmus was done under local anesthesia. Post-operative course was again uneventful and she was discharged from the hospital on

the sixth postoperative day.

PATHOLOGY REPORT: Gross: The specimen consists of the right lobe of the thyroid gland which is slightly irregular. Sections through the gland show it to contain, in the central portion, a nodule surrounded by dense fibrous connective tissue. The nodule measures 1.5 cms. in diameter. In the periphery of the gland there is a small mass of firm tissue measuring 5 mms in diameter surrounded by thyroid tissue.

HISTOPATHOLOGY: Sections through the nodular mass of tissue show large irregular shaped acini lined by flattened cells. Occasional acini are lined by columnar epithelial cells. The nodule is surrounded by a dense hyalinized fibrous connective tissue capsule. Sections through the small nodule at the periphery of the gland show it to be composed of irregular shaped acini formed by large hyperchromatic cells. Occasional papillary projections are seen. This tissue also appears to infiltrate the surrounding fibrous tissue.

DIAGNOSIS: Thyroid gland containing a colloid adenoma with areas of intra-adenomatous hypertrophy and hyperplasia. Small papillary, grade 1, adenocarcinoma in the periphery of the gland.

To date there has been no sign of recurrence. Radical neck dissection and x-ray therapy were not advised due to grade and type of the lesion.

Case 3. Mrs. A. N., 145007, 77-year-old white female, admitted to the hospital December 14, 1950, complaining of "lump in neck." This was first noticed about four months previous to admission, and has grown quite rapidly. Complained of some pressure symptoms, but had no symptoms of toxicity. Past history not contributory.

PHYSICAL EXAMINATION: Temperature 98.6, pulse 72, respiration 20, and blood pressure 150/60. General physical examination essentially negative except for a firm, nodular, rather fixed tumor mass in region of thyroid gland measuring approximately 7 cm. by 7 cm. The right side of the mass was more prominent and more firmly fixed to the surrounding structures. Laryngoscopic examination normal. Laboratory records: blood count and urinalysis essentially normal. Blood Kahn negative. B. M. R. plus 26. X-ray examination of the chest and cervical region showed the lungs to be clear, but there

was a soft tissue mass in the neck causing deviation of the trachea to the left.

She was given five days preparation of Lugol's solution and Phenobarbital and then operated on under intratracheal general anesthesia. Upon exploration of the thyroid gland it was found that both lobes were involved in the tumor growth, and on the right side the tumor had invaded the wall of the internal jugular vein. A total thyroidectomy was done along with a 4 cm. section of the internal jugular vein on the right side. Recovery was uneventful and the patient was discharged from the hospital on the seventh postoperative day.

PATHOLOGY REPORT: Gross. The specimen consists of an irregularly shaped mass, weighing 85 grams, from the right lobe of the thyroid. The tissue cuts with resistance and the surface of the cut section is gray.

HISTOPATHOLOGY: Sections from the tumor in the thyroid show it to be composed of round cells with hyperchromatic nuclei. The cells are medium in size and show mild variation in size and shape. There is a fairly abundant connective tissue stroma. The tumor is seen infiltrating the thyroid tissue and surrounds a nerve trunk in the capsule. In other areas the structure is that of stroma lymphomatosa, but in this neoplastic tissue can be recognized. The thyroid tissue outside of the tumor does not show hyperplasia.

DIAGNOSIS: Large reticulum cell sarcoma of the thyroid. It was the recommendation of the roentgenologist that x-ray therapy not be given at the present time, however, if a local recurrence should develop the patient should receive roentgen ray therapy.

Summary

A brief review of the literature on carcinomas of the thyroid gland has been presented.

It is felt that the solitary adenoma of the thyroid gland is a true neoplasm. The incidence of malignancy in such lesions is between ten to twelve per cent. Surgical removal of all solitary thyroid adenoma is recommended. Three cases of malignant tumors of the thyroid gland have been presented.

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DISCUSSION

Malcom Thompson, M. D., Louisville: Dr. Strode has presented to us ably and well what is now known about this serious and treacherous disease. I rise to present some incidents of my own in the hope of adding emphasis to what he has just said.

From a false conception of the natural history of diseases of the thyroid, many internists and even a few surgeons do not advise excision of nodular goiter unless it is causing symptoms such as toxicity, dysphagia and

dyspnea. For example, in 1947 in one of the better journals there appeared the following: "It is not believed that all nodular goiters should be removed. Despite 'prophylactic' surgery on benign or clinically unsuspected malignant goiters, lesions may later develop or frequently recur. Moreover, operations on patients with non-toxic goiter are associated with a significant number of complications and are sometimes fatal."

This conclusion was so at variance with my knowledge of the proper treatment of nodular goiter that the editor was written as follows: "Many years ago Dupuytren told his students, 'Diagnosis holds the first rank in our science and is the most difficult part of it; without an exact and precise diagnosis theory is always faulty and practice often incorrect.' If possible it is the chief duty of an attending physician to make an exact and precise diagnosis and when a patient is attended who has a nodule in the thyroid gland, I know of no way of making such a diagnosis without excising the diseased area and submitting it to a microscopist competent in the diagnosis of tissues."

Subsequent experience has strengthened rather than weakened that opinion for since it was written I have attended four adult patients who upon physical examination had non-toxic nodular goiter with no suspicious signs or symptoms of malignancy but who upon microscopic examination of the specimens had cancer. Two of these were single nodules which were excised widely with all of the ipsilateral lobe. The third had had a large multinodular goiter for many years. Following excision she was given x-ray treatment as the pathologist reported a highly malignant type of cell. The fourth had multiple soft nodules and therefore considered by some physicians most unlikely to be malignant. Metastases to the cervical lymph nodes, the so-called lateral aberrant thyroid, appeared only a few weeks following thyroidectomy. These were excised by means of a complete unilateral neck dissection. To date there are no signs of recurrence in these patients.

C. H. Maguire, M. D., Louisville: I should like to support Dr. Strode's excellent paper by saying that carcinoma of the thyroid is too often not recognized at the time of operation. This raises the question, "Should we go back into the neck when the report comes in three days later that the thyroid removed was carcinoma?" I think by all means we should go back and do a total lobectomy on the side of the lesion. Better than this is a plan I am recommending and that is to do a total lobectomy at first operation on any solitary nodule in the thyroid in this way obviating a later

trip into the neck.

I have recently had a ten-year-old boy with extensive carcinoma of the thyroid which at operation I found extended into the trachea and the esophagus. It was extremely bloody and there was no chance to remove it all so I stopped, introduced a tracheotomy tube and as soon as the patient recovered sufficiently from the operation sent him to Oak Ridge, Tennessee, for treatment with radio-active iodine. Two months after he had been at Oak Ridge I went down and operated on the boy and removed the left lobe of the thyroid which was relatively normal and had been absorbing the radio-active iodine. Incidentally all the sponges were checked for radio-active iodine after the operation and I was told at the conclusion of the operation that I had received a maximum dose of radiation myself. After removal of the normal thyroid tissue radio-active iodine treatment was continued successfully so that two years after the first operation all of the original growth and all of the metastases have disappeared. The boy is in excellent condition but his neck is board-like due to heavy scar tissue. Recently it has been reported in Chicago that papillary lesions of the thyroid without colloid do not pick up radio-active iodine but if patients with this type of thyroid are treated with thyrotropic drugs the gland will pick up iodine. All of this emphasizes that in dealing with carcinoma of the thyroid it is our duty to use all of the agencies available.

A. E. Grimes, M. D., Lexington: I just want to emphasize two things: 1—Carcinomas are often found quite accidentally in adenomas. I

recently operated on a patient with hemorrhage into the gland causing a swollen painful lobe. This followed an accident (wrestling) I removed the lobe with the hemorrhage in it and it was reported a nonpapillary carcinoma, grade 1. The other point I am emphasizing is that accessory, or so-called aberrant thyroid tissue, is always metastatic carcinoma of the thyroid. I believe but I am not certain that this was established by Pemberton. I recently removed lymph nodes in a posterior cervical chain and these were reported as papillary thyroid carcinoma. I went back later and explored the lobe on that side and removed it and it was reported to be normal.

C. M. Bernhard, M. D., Louisville: I simply wish to point out that not all goiters with apparent cervical metastasis are carcinoma of the thyroid. I have recently had a 65-year-old woman with a nodular thyroid gland, bilateral palpable nodes, a substernal mass and with dyspnea due to tracheal pressure. Needle biopsy showed that this lesion was a lymphoblastoma and she has been temporarily relieved by x-ray therapy and I have saved her an unnecessary and perhaps fatal operation.

E. C. Strode, M. D., Lexington, (In closing): I am very grateful for the free discussion and I think the points brought out were well worth while. I think almost all agree now that aberrant thyroid tissue always represents a metastasis, whether the original lesions can be found or not.

(Dr. Strode then reported his third case which is in the body of the paper above and which he did not have time to report in the twenty minutes allowed.)

Acute Benign Pericarditis Simulating Acute Myocardial Infarction

WILLIAM H. ROSENBLATT, M. D.

HERBERT L. CLAY, JR., M. D.

Louisville

As pointed out by Logue and Wendkos¹ as well as by others,²⁻⁶ cases of acute pericarditis are still being confused with coronary artery disease. This is especially significant since reports of coronary artery disease and/or myocardial infarction in the younger age groups have begun to appear more and more frequently in the literature^{7,11-17}. At times the differentiation between acute pericarditis and myocardial infarction becomes difficult. It is, therefore, the purpose of this report to emphasize this by presenting an illustrative case.

Case Report

Mrs. E. S., a twenty-six-year-old white housewife and commercial candy-maker, was admitted to the Medical Service of the Jewish Hospital about noon February 14, 1951, with the complaint of severe chest pain of about twenty-four hours' duration. She stated that with the exception of a "tired feeling" for about three weeks prior to this admission, she had been in good health. She attributed her tiredness to an increase in the work-load of her candy-making business which she conducted in her home. About 11:00 a. m. February 13, 1951, immediately after receiving a telephone call notifying her of the sudden death of her twenty-eight-year-old husband, she developed severe pains in the back of her chest "high up" about the level of the "shoulder-blades" and "more to the right." The pain persisted throughout that day and evening, and seemed to be aggravated by deep breathing. During that day and evening she also noticed a dry hacking cough, felt nauseated and vomited several times. The morning of admission to the hospital she stated that

the pain in the back of her chest had practically subsided and seemed to have been replaced by a constant severe pain across the front of her chest. She described this pain as being deep and crushing. The cough, nausea and vomiting had cleared.

A review of the symptoms was otherwise non-contributory.

Past History

Past history revealed that the patient had been taking three grains of thyroid daily from 1944 to 1947 because she had been told that her basal metabolism rate was below normal. She was examined by the writer February 18, 1948, as a routine "check-up." No physical abnormalities were detected at that time. A B. M. R. was done five days later and a reading of minus 19% was obtained. Thyroid was prescribed in the dosage of two grains daily. A repeat B. M. R. was performed June 30, 1948, and a reading of plus 1% was obtained. The patient continued taking thyroid until the onset of her present illness.

Family history was non-contributory with the exception that her father died at the age of thirty-seven of "heart trouble."

Physical Examination

Physical examination on admission to the hospital revealed a well-developed, well-nourished white adult female of stated age, appearing acutely ill. Temperature 100.4 degrees, pulse rate 120, respiration 24, height 5'8", weight 147½ pounds. Blood pressure right arm 86/60; left arm 80/60. Moderate cyanosis of the nail beds was present. The lung fields were normal on auscultation and percussion. A definite presystolic gallop rhythm was detected over the entire precordium. No murmurs were heard. She was placed under an oxygen tent (oxygen flowing at rate of 8 L/min.). Serial electrocardiograms were made and revealed progressive changes of acute pericarditis. (Fig. 1).

From the Department of Medicine, Jewish Hospital, Louisville, Kentucky.

1. Clinical Instructor in Medicine, University of Louisville School of Medicine.

2. Associate Professor of Medicine, University of Louisville School of Medicine.

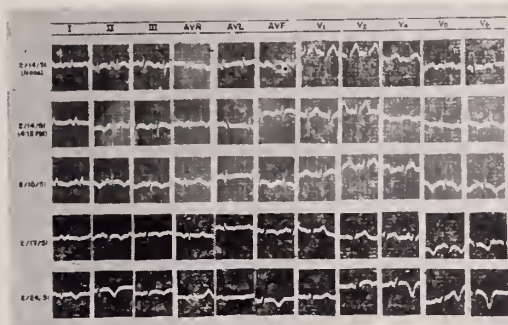


Figure 1

It will be noted that in the tracing taken 2/14/51 (24 hrs. after onset of pain) T wave changes in the limb leads have begun to appear. S-T elevation with bowing upwards will be noted in leads 1, 2, 3, AVF, V4, V5 and V6. Records 4 hrs. later show similar changes with inversion of T waves in V4, V5 and V6. 48 hrs. later further T wave changes have occurred, namely, inversion leads 1, 2, 3 with deep inversion in V6. Tracings taken 2/17/51 and 2/24/51 illustrate the progressive changes of acute pericarditis.

Ballisto Records

Blood counts on admission and during the period of hospitalization were consistent with the clinical picture and have been tabulated (Table 1.). The erythrocyte sedimentation rates were repeated at intervals and have been tabulated (Table 2.). Urinalyses on two occasions revealed no abnormalities. A blood cholesterol determination was done seven days after admission and was reported to be 116 mgm%. X-ray films of the chest were made on the day of admission to the hospital and again

twenty-one days later. "Some lace-like infiltration in the first and second right interspaces with streamers extending from the hilus out toward this area along with increase in bronchial markings in the right base" were described by the roentgenologist in the first film (Fig. 2A). A disappearance of these findings was reported in the second film (Fig. 2B).

The patient's temperature gradually subsided by lysis from the initial 100.4 to normal on the ninth hospital day. The tachycardia persisted for seven days, after which time the pulse rate ranged from seventy to eighty beats per minute. During the last week of hospitalization a bradycardia developed and persisted, the pulse rate ranging between fifty and sixty beats per minute. The presystolic gallop rhythm disappeared 48 hours after admission to the hospital. The blood pressure readings ranged from 80/60 to 90/70, during the first two weeks, after which time they ranged from 110/70 to 118/70.

The chest pain gradually subsided during the first forty-eight hours; however, she complained of transitory mild pressure sensations in the left anterior and left lateral portions of her chest, recurrently, during her hospital stay. The discomfort was not influenced by position changes or deep inspiration.

Discussion

The clinical picture presented by this woman during the first forty-eight hours of observation was very suggestive of acute myocardial infarction, although acute pericarditis could not be ruled out. It is known that oftentimes the symptoma-

TABLE I
BLOOD COUNTS

Date	RBC	Hgb. (gms.)	WBC	Easo.	Eosino.	Stabs	Segs.	Lymphs	Mono.
2/14/51	4,270,000	13	16,200				81	19	
2/15/51			13,100						
2/16/51			8,250						
2/19/51	4,140,000	12.5	8,200	1	3	4	49	41	2
3/ 8/51	4,460,000	13	5,300				69	28	3

TABLE II
SEDIMENTATION RATES*

Date	Uncorrected	Corrected	Hematocrit
2/14/51	12	12	41%
2/15/51	22	19	40%
3/ 8/51	5	5	42%

*Wintrobe method. Rates recorded as fall at the end of 60 minutes.

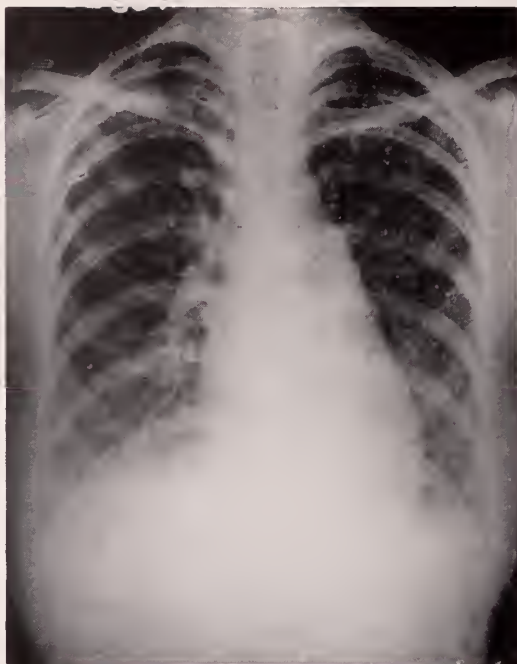


Figure 2-A



Figure 2-B

tology as well as the physical findings at the onset of acute pericarditis may resemble those of acute myocardial infarction⁵. In this case the patient was apparently in good health prior to the sudden, profound emotional shock induced by the unexpected news of her husband's abrupt demise. Her chest pain developed moments after

the telephone call. The possibility that such a situation might precipitate an acute myocardial infarction, although remote, and suggested by Reich¹¹, who reported a case of acute myocardial infarction associated with a sudden severe anxiety state, obesity, hypertension and diabetes, was entertained early in this case. The electrocardiographic changes twenty-four hours after the onset of pain were considered to be suggestive of acute antero-septal infarction. It was only after serial electrocardiograms, which revealed the classical T wave changes in the limb leads and in V4, V5, and V6, that the correct diagnosis became apparent. Several other interesting features are manifested by this case; namely, that ordinarily it is expected that the elevated S-T segments found in acute pericarditis are concave in contrast to the convex or cove-plane segments seen in myocardial infarction¹; however, in this instance it will be noted that the elevated S-T segments were coved. To further exclude myocardial infarction from a purely electrocardiographic viewpoint, Q waves were not present nor were there reciprocal S-T segment changes in leads 1 and 3; R waves were not absent in the chest leads.

Generally, a pericardial friction rub is heard in acute pericarditis and persists for a variable period of time¹⁻³. In this particular case, a friction rub was at no time detected during the entire period of hospitalization.

Benign pericarditis, following or associated with a variety of upper respiratory tract infections has been reported¹⁻³⁻⁸. Its association with acute pneumonitis has been described⁹; also with primary atypical pneumonia¹⁰. Although repeated physical examinations of this patient's chest failed to reveal any signs of pulmonary disease, the chest x-ray on admission to the hospital indicated an inflammatory process in the right base as well as in the first and second intercostal spaces. These x-ray findings were not present on a re-check twenty-one days later. On the basis of these findings, a pneumonitis or possibly a virus pneumonia must be assumed to have been present although cold agglutination tests were not performed.

Conclusion

A case of acute pericarditis clinically simulating acute myocardial infarction occurring in a young white female is presented.

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Special Article

Daniel Drake and His Medical Classic*

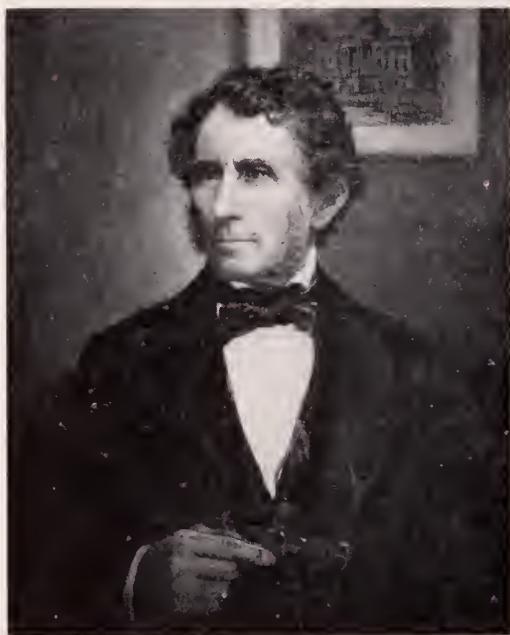
EMMET FIELD HORINE, M. D.

Brooks, Ky.

The great book lover, student of the history of medicine, erudite teacher and clinician, Sir William Osler (1849-1919) once wrote:

For many years there was in this country a group of peripatetic teachers who went from town to town, like the Sophists of Greece, staying a year or two in each, or divided their time between a winter session in a large city school and a summer term in a small country one. Among them Daniel Drake takes the precedence. . .¹

In another place, Osler said: "In many ways Daniel Drake is the most unique figure in the history of American Medicine. . ."²



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DANIEL DRAKE, M. D.

20 October 1785—5 November 1852

*Address delivered in Emory University, Ga., before the Georgia Beta Chapter of Alpha Omega Alpha, Emory University School of Medicine, 22 February 1951.

1. William Osler: *An Alabama Student and Other Biographical Essays*. London: Henry Frowde, 1909, pp. 116-117.

2. Sir William Osler: *Aequanimitas with Other Addresses*. 3d Ed. Philadelphia: P. Blakiston's Son & Co., 1932, p. 307.

The remarks of Sir William Osler will, I trust, give you some immediate idea of the reasons why it is a real pleasure for me to comply with your request and discuss with you some of the accomplishments of Daniel Drake.

He was one of the best known medical teachers, authors and editors in the whole of the United States during the second quarter of the nineteenth century. I have elected to picture him tonight as he is revealed by his written words and by the methods employed in their writing. I have been led to do this for many reasons, among them being that "in every man's writings, the character of the writer must be recorded."³ However, since Drake's total extant writings amount to over three thousand items, they, obviously, cannot all be covered. I shall, therefore, center my remarks around his medical classic, entitled: *A Systematic Treatise, Historical, Etiological and Practical, on the Diseases of the Interior Valley of North America, as they appear in the Caucasian African, Indian, and Esquimaux Varieties of its Population*.⁴ Concerning this amazing work, Fielding H. Garrison (1870-1935), the famous medical historian, bibliographer, and librarian of the Welch Memorial Library at Johns Hopkins University, wrote as follows:

There was nothing like this book in literature, unless it be Hippocrates on Airs, Waters, and Places, and even Hippocrates made no attempt to map out or triangulate the geographic locale of disease. . .⁵

It is clear then that we have to do with a really great man, whom some have call-

3. Thomas Carlyle: *Goethe, Edinburgh Review*, 1828. (In Bartlett: *Familiar Quotations*, 12th Ed., 1948, page 376, but considerable search has failed to verify.)

4. The first volume of xvi plus 878 pages was published in 1850 at Cincinnati by Winthrop B. Smith & Co. The second of xix plus 985 pages had been practically completed before Drake's death in 1852. It was edited by Drs. S. Hanbury Smith and Francis G. Smith and published in 1854 at Philadelphia by Lippincott, Grambo & Co.

5. Fielding H. Garrison: *An Introduction to the History of Medicine*, 3d Ed. Philadelphia: W. B. Saunders Co., 1924, p. 465.

ed a genius.^{6,7} Such a man's antecedents, environment and education will be of interest.

Daniel Drake, the second child of Isaac (1756-1832) and Elizabeth (Shotwell) Drake (1761-1831), was born in Essex County, New Jersey, on 20 October 1785. When Daniel was less than three years of age, his father, a farmer, and his father's two brothers with their families moved to Kentucky. Here Isaac Drake's home was a one room log cabin with a single door. Because of the danger of Indian raids, there were no windows. Daniel's early schooling was desultory under itinerant and poorly trained teachers. At the age of fifteen, with little more than a smattering of reading, writing and arithmetic, he was apprenticed as a medical student to "Dr." William Goforth (1766-1817) of Cincinnati, Ohio.⁸

Throughout the early colonial period few physicians were graduates in medicine. Apprenticeship was the customary plan for obtaining medical knowledge. It has been estimated that during the Revolution, of the approximately 3,500 physicians, not over 350-400 held medical degrees.⁹ By 1800, when Daniel Drake began the study of medicine, it is probable that the ratio of physicians with degrees to those without had been greatly reduced as a result of the suspension of the few medical schools in America during the Revolution.

Young Drake was indefatigable and possessed an eager mind with retentive memory as is shown by progress so rapid that his preceptor, "Dr." Goforth, took him into partnership in less than four years. It was then that "Dr." Goforth gave his pupil a diploma, the first issued west of the Allegheny Mountains. This attested to Drake's knowledge of *physic, surgery and midwifery*.¹⁰ A year later (1805), Drake rode horseback over the mountains and on to Philadelphia where he attended his first course of medical

lectures at the University of Pennsylvania. His teachers were such famous men as Benjamin Rush (1745-1813), Benjamin Smith Barton (1766-1815), Philip Syng Physick (1768-1837), Casper Wistar (1761-1818) and James Woodhouse (1770-1809.)

Returning to Kentucky he practiced for a year at Mayslick near his father's home. Here he observed an epidemic, possibly of typhoid fever, the record of which represented his first venture in the field of medical literature.¹¹ It was a significant and, incidentally, very early contribution to epidemiology in the United States, the first by a physician living west of the Allegheny Mountains.

X. *Some Account of the Epidemic Diseases which prevail at Mays-Lick, in Kentucky. In a letter to the EDITOR, from Dr. DANIEL DRAKE.*

TO fill up this sheet, I will copy from my common-place-book some observations on the topography and diseases of that part of Kentucky in which I lived, after my return from Philadelphia, till about three months ago. The village in which I lived is 12 miles from the Ohio. It is remote from any marsh, pond, or considerable stream of water; the land is fertile and rolling; the

From *The Philadelphia Medical and Physical Journal*, 111 (Part 1): 85, 1808.

In 1807, at the suggestion of his preceptor who was leaving Cincinnati, Drake located there and soon acquired a large practice. His next publication, *Notices Concerning Cincinnati*, appeared in 1810.¹² This dealt with the topography, meteorology, botany and medical conditions found there. It was the first comprehensive account of a mid-western town and, together with a much expanded version issued in 1816, did much to attract immigrants.¹³ In these books appeared the first description of a hitherto unknown local malady, now called *trembles* or *milk-sickness*.

In 1815, Drake attended a second course of lectures in the Medical Department of the University of Pennsylvania and, at a convocation especially arranged for this

6. James Thomas Flexner: *Genius on the Ohio—Daniel Drake [in] Doctors on Horseback*. New York: The Viking Press, 1937. pp. 165-234.

7. Mary Louise Marshall: *The Versatile Genius of Daniel Drake*. *Bull. Med. Library Assn.*, XXXI: 291-318, October 1943.

8. Daniel Drake: *Pioneer Life in Kentucky*. Edited by Emmet F. Horine, New York: Henry Schuman, [1948]. pp. 235-247.

9. Joseph M. Toner: *Contributions to the Annals of Medical Progress and Medical Education in the United States*. . . Washington: Government Printing Office, 1874, p. 106.

10. Daniel Drake: *Discourses*. . . *Before the Cincinnati Medical Library Assn.* Cincinnati: Moore and Anderson, 1852, p. 56.

11. Daniel Drake: *Some Account of the Epidemic Diseases which Preval at Mays-Lick in Kentucky*. *The Philadelphia Med. and Physical J.* III (Part 1): 85-90, 1808.

12. Daniel Drake: *Notices Concerning Cincinnati*. Printed for the Author, at the Press of John W. Browne & Co., 1810.

13. Daniel Drake: *Natural and Statistical View, or Picture of Cincinnati*. . . Cincinnati: Looker and Wallace, 1815. (Due to delay in securing the maps which were printed in Philadelphia, this book was not issued until 16 February 1816.)

purpose, was granted the degree of M. D. on 11 May 1816.¹⁴ Returning to Cincinnati, he became its most prominent physician and civic leader. He was instrumental in founding a public library, a school of literature and arts and a Lancastrian seminary to which was attached a grammar school.

When the Medical Department of Transylvania University, Lexington, Kentucky, was at last opened in 1817, Drake accepted the Professorship of Materia Medica and Medical Botany.¹⁵ However, apparently unhappy because of dissensions in the Faculty, he resigned after the close of the 1817-18 session and returned to Cincinnati. Here, with two associates, he began a systematic course of medical lectures for private pupils.¹⁶

By personal solicitation in 1819, Drake secured from the General Assembly charters for The Medical College of Ohio and for Cincinnati College.¹⁷ Because of the difficulty in securing a full faculty, The Medical College of Ohio did not open until 11 November 1820. At this time, President Drake delivered an *Inaugural Discourse on Medical Education* which even today is stimulating and of great historical importance.¹⁸ Just thirty-five years of age, Drake had already made spectacular strides since 1800 when as a poorly educated and shy country boy he had begun the study of medicine. Through his own unaided efforts, he had obtained his degree in medicine and a wide knowledge of literature. He had learned Latin sufficiently well to read not only the older medical authors but to compose and deliver an oration in that language. Unquestionably he had a reading knowledge of French and it is probable that he knew some German. As early as 1820, his first two books and several brochures had earned for him a national reputation. He was the leader in founding the Western Museum at Cincinnati, the first of its type in the West, and in which John James

Audubon (1780-1851) was employed for awhile.¹⁹

Again going before the General Assembly of Ohio, Drake secured a charter for the Commercial Hospital and Lunatic Asylum in 1821. The professors of The Medical College of Ohio were designated as the visiting physicians and the students of said college were to be admitted to the wards. This was the first hospital in the United States established primarily for teaching purposes and staffed exclusively by the professors of a medical college.²⁰ It antedated by more than half a century the pavilion built in 1877 by the University of Michigan which Abraham Flexner erroneously termed "the first university hospital in the United States."²¹ Concerning bedside teaching, Drake's ideas were expressed as follows:

. . . The laboratory is not more necessary for the study of chemistry or a garden of plants for the study of botany, than a hospital for the study of practical medicine and surgery. . .²²

Space permits merely an enumeration of his various professorships. These were: Transylvania University (1817-18, 1823-27); The Medical College of Ohio (1819-1822, 1831-32, 1849-50); Jefferson Medical College, Philadelphia (1830-31); Miami University, Medical Department (organized by him but never opened, 1831); Medical Department of Cincinnati College (founded by him, 1835-38); The Louisville Medical Institute, now the School of Medicine of the University of Louisville (1839-49, 1850-52); and finally his return to his first love, The Medical College of Ohio (1852.)

Dr. Lunsford P. Yandell, Sr. (1805-1878), early teacher in Transylvania University and in The Louisville Medical Institute, author and editor, wrote toward the close of his distinguished career: "In the whole course of my life I have met with few men superior to Dr. Drake in his wisdom. . ."²³ Dr. Samuel D. Gross

14. Charles D. Meigs: *A Biographical Notice of Daniel Drake*. . . Philadelphia: Lippincott, Grambo, and Co., 1853.

15. Emmet F. Horine: Early Medicine in Kentucky and the Mississippi Valley. . . *Journal of History of Med. and Allied Sciences*, III:263-278, 1948.

16. Daniel Drake et al.: Medical Instruction [Ad.] *Liberty Hall and Cincinnati Gazette*, XIV. p. [3]-c. [1], May 27, 1818.

17. Ohio: *Acts of General Assembly*. Chillicothe: Geo. Nashee, 1819, XVII:37-40 and 46-50.

18. Daniel Drake: *An Inaugural Discourse on Medical Education*, Cincinnati: Looker, Palmer & Reynolds, 1820. Reprinted with an introduction by Emmet Field Horine. New York: Henry Schuman, (1951.)

19. *Audubon's America*. Edited by Donald C. Peattie. Boston: Houghton Mifflin Co., [1940], pp. 13-14.

20. [Editorial]: The Hospital. *Liberty Hall and Cincinnati Gazette*, N. S. II, P. [3]c. [1], Jan. 20, 1821.

21. Abraham Flexner: *Daniel Coit Gilman, Creator of the American Type of University*. New York: Harcourt, Brace & Co., [1946]. p. 142.

22. Daniel Drake: *Introductory Lecture at the Opening of the Thirtieth Session of the Medical College of Ohio*, Nov. 5, 1849. Cincinnati: Morgan & Overend, 1849, p. 15.

23. Lunsford Pitts Yandell: *Memoranda*, Ms., p. 17. [This ms. is owned by Charles F. Wood, M. D., who graciously allowed access to it.]

(1805-84), renowned surgeon, author and teacher, closely associated with Drake for over fifteen years, wrote: "of all the medical teachers whom I have ever heard, he was the most forcible and eloquent."²⁴ Dr. William J. Barbee (1816-92), physician, author, teacher and preacher, said: "As a professor, Dr. Drake, in my estimation, is not second to any man in the United States. . ."²⁵

In 1819, Drake had issued proposals for the publication of a medical journal in Cincinnati and obtained over two hundred subscriptions. However, his many other projects at the time prevented him from starting this periodical. When his friend, Dr. John D. Godman (1794-1830) who had been Professor of Surgery in The Medical College of Ohio, resigned in 1822 and started *The Western Quarterly Reporter of Medical, Surgical and Natural Sciences*, Drake generously turned over to him his own list of subscribers.

The Western Quarterly Reporter. . . was the first medical journal to be established west of the Allegheny Mountains. This fact in itself is of considerable importance. But for our purposes this evening it has special significance. For it was in the third issue of this periodical that Drake announced his intention of preparing a "*Treatise on the Diseases of the Western Country*."²⁶ He requested readers to supply him with a wide assortment of scientific information which they might have and be willing to place at his disposal. His first contribution to medical literature which has been previously mentioned,²⁷ as well as his second, *Notices Concerning Cincinnati*, and its expanded version²⁸ might each be termed germ-plasm of the projected work. In his request for information Drake listed twenty-six categories of investigation. He especially desired knowledge concerning the effects on health "produced by the soil, climate, diet and drinks, occupations and pursuits" of the people. Information was requested concerning premature decay of teeth and the influence of climate, negli-

gence, indigestion and tobacco on decay. What were the morbid effects of premature marriages and what prolongation of life might be expected by immigration to the western states? Knowledge was sought concerning diseases of Indians and Negroes. What special diseases, if any, occurred at the lead mines or salt works? Details of autopsies were desired.

From all this it is clearly apparent that his book was projected upon the broadest possible foundation which included sociological studies in relation to diseases as well as topographical, geological, meteorological and botanical relationships.

Unduly optimistic concerning the time required to complete his investigations, Drake concluded his request of 1 September 1822 as follows: "Communications made at any period before the end of the year 1823, will be in time to answer the purposes intended." However, as things were to turn out, Drake would have been safe in fixing a far later "deadline" than the end of 1823 for receiving information. No doubt his appeal for facts evoked only a limited response; but over the years there were also to be many other deterrent influences. These began with the machinations of his jealous enemies, his acceptance (1823) of a professorship in Transylvania University, Lexington, Kentucky, and especially the death of his accomplished and beloved wife in 1825.

When John D. Godman ceased publication of *The Western Quarterly Reporter* . . . and left Cincinnati, he gave his material to Drake who planned to continue the periodical at Lexington, Ky., but failed to do so because of his inability to find a publisher. Later, in 1827, resigning his professorship at Transylvania University, Drake returned to Cincinnati and joined with Dr. Guy W. Wright (d. 1831) to establish *The Western Medical and Physical Journal, Original and Eclectic*. The first issue appeared in April 1827. In it (page 69) we find the following announcement:

Diseases of the Western Country.—The undersigned, some time since, issued a circular letter to the physicians of the Mississippi states, soliciting from them such facts and observations as would aid him, in the composition of a history of the diseases which occur between the Gulph of Mexico and the lakes. He wishes now to say, that the work which he then

24. Samuel D. Gross: Daniel Drake [in] *Lives of Eminent American Physicians and Surgeons*. . . Philadelphia: Lindsay & Blakiston, 1861.

25. W. J. Barbee: Letters from the West—No. 5. *The Boston Med. and Surg. J.*, XXI:96-98, September 18, 1839.

26. Daniel Drake: *Treatise on the Diseases of the Western Country*. *The Western Quarterly Reporter of Medical, Surgical and Natural Sciences*, (Cincinnati, Ohio) Vol. I:307-311, 1822.

27. *Loc. cit.*, Reference 11.

28. *Loc. cit.*, References 12 and 13.

announced, has not been abandoned, though deferred in consequence of various official duties; but that having divested himself of these, he hopes, at no distant time, to engage seriously in the undertaking. He returns his thanks to the gentlemen who have favoured him with communications, and will thankfully receive from others what may be adapted to the plan of such a work.

Daniel Drake, M. D.

Cincinnati, Ohio, March, 1827.

Yet, even now his enormous practice, the responsibilities of the eye infirmary he had just established, editorial duties and a multiplicity of civic as well as professional projects prevented intensive work on his proposed book.

Nearly ten years went by, and it was not until 1 April 1836 that Drake again announced plans for the continuation of his investigations for a "Medical History of the West."²⁹ By this time he had come to a fuller realization of the magnitude of the undertaking upon which he had embarked. He stated now that he intended to resort "to travelling as the only mode on which reliance can be placed. By visiting the principal localities on the great platform, between the Lakes and the Gulph of Mexico, several important acquisitions can be made, either by direct personal observation, or by intercourse with gentlemen resident in different places. . ." He promised that full credit would be given to all those assisting him and, therefore, the book would be "from the physicians of the West—a work of reciprocal instruction—somewhat novel in the manner in which it is gotten up—limited to the diseases of the region of which it professes to treat—not dependent on the written archives of the profession for facts, but copious in its acquisitions from cotemporary observers."

Drake stated that he would leave Cincinnati about the middle of May 1836 and would first pass through Indiana, Illinois and on into Missouri. From there he planned to go to Alabama, then Tennessee, Kentucky and on into eastern Ohio whence he would return to Cincinnati. For a man past fifty, this was a strenuous itinerary, considering the wretched accommodations and modes of

travel: "in skiffs, on rail roads, in stages, buggies, common wagons, on horseback, muleback and on foot, by night and by day. . ."³⁰ We are fortunate in having accounts of many of the places visited, since Drake embodied some of his observations in editorials, *Traveling Memoranda*, *Traveling Editorials*, which were published in his medical journal. His alertness to every phase of human activity is clearly revealed by these letters, twenty-five in number. Although hurriedly written, their flowing style and clearness of presentation make them models.

Writing from St. Louis, Mo., on 6 June 1836, Drake gives an interesting description of the city, its inhabitants, the physicians and their Medical Society of Missouri, the first established west of the Mississippi. The St. Louis Hospital, managed by the Sisters of Charity, was "furnished and kept in a style of great comfort and neatness." He was not blind to general conditions:

*The city is built on a gentle declivity, highly favorable to cleanliness; but its municipal authorities do not seem to pay any special attention to the 'art and mystery' of scavengering. . .*³¹

By 15 July 1836, Drake was at the health resort of Monte Sano, two miles east of Huntsville, Alabama.³² He was enthusiastic concerning this section of the state but critical of its use of feather beds:

*It is bad enough to sleep in feathers in summer, when one lives far in the north; but to be delivered over to such a fate, in the latitude of 34° is deplorable. Every where in this region, the taverns, and, in general, the houses of the people, are furnished with feather beds, for June, July and August, not less than for January. The medical gentlemen of this country should raise their voices against this absurd and enervating custom. A hard bed for hot weather referring rather to health or comfort, should be the motto of the whole South.*³³

He noted that many of the practicing physicians were not graduates of any in-

29. Daniel Drake: *Medical History of the West. The Western J. of the Med. and Physical Sciences*, (Cincinnati, Ohio), Hexade II, Vol. III:679-685, Jan., Feb., March 1836.

30. Daniel Drake: *Traveling Letters from the Senior Editor, No. X. The West. J. Med. and Surgery*, (Louisville, Ky.), New Series Vol. II:545-548, Dec. 1844.

31. Daniel Drake: *Traveling Memoranda. The Western J. of the Med. and Physical Sciences*, (Cincinnati, Ohio), Second Hexade, IV:311-319, July, Aug., September 1836.

32. *Ibid.*, p. 315.

33. *Ibid.*, p. 317-318.

stitution, a situation which, of course, he deplored. Among those with degrees there were more graduates of the University of Pennsylvania than of Transylvania University; and this surprised him. He had other remarks on the state of the medical profession:

*The practitioners south of the Ohio river, receive much better fees than those to the north; but then the price of everything in the former, is higher than in the latter. . . Nevertheless, even its ablest members are perpetually leaving it for more lucrative pursuits. . . This premature renunciation of what men have laboriously qualified themselves to prosecute, is manifestly not without a cause. . . The period of greatest usefulness, in the life of a physician, extends from 40 to 60—he it not a man of wisdom before the former, nor of energy, after the latter term. . .*³⁴

A trip of 114 miles from Huntsville, Alabama, by stage coach, brought him to Nashville, Tennessee, from where he wrote on 21 July 1836. The scenery and geological formations along the way are described. He mentions the physicians of Nashville and suggests that a medical department should be organized as part of the University. He is especially warm in his praise of Gerard Troost (1776-1850), Professor of Chemistry, Geology and Mineralogy in the University of Nashville, whose collection of minerals was, at that time, the largest privately owned one in the United States.³⁵

By 27 July 1836, Drake was in Harrodsburg, Kentucky, at Graham's Springs, whose "hundred lights, distributed throughout the immense group of cottages, and illuminating the surrounding shrubbery, gave it the appearance of fairyland. . ."³⁶ Incidentally, this was the most popular watering resort in the United States at that period.³⁷ He tarried for a week at the springs and then went on to Lexington, Ky. From there, on 8 August 1836, he wrote of Transylvania University, of the medical societies and of the Lunatic Asylum of Kentucky which he suggested as a model for similar institutions. Not only was the Asylum excellently managed by

its trustees and the experienced physician in charge but also "the accommodations are extensive and well arranged; the warming and ventilation are effected by proper means [and] cleanliness, quiet and order, are obvious in every part. . ."³⁸

During the following two years (1837-38), Drake was too busily engaged in his professional work and that in behalf of the Medical Department of Cincinnati College to continue actively to gather material for his book. When this institution closed, Drake accepted the Professorship of Clinical Medicine and Pathological Anatomy, a Chair created especially for him, in The Louisville Medical Institute in 1839. He transferred his medical journal to Kentucky, where it was consolidated with *The Louisville Journal of Medicine and Surgery* to form *The Western Journal of Medicine and Surgery*. The first number was issued 1 January 1840 under the editorship of Daniel Drake and Lunsford P. Yandell, Sr.

Drake was apparently quite happy in Louisville and he soon had a large consultative practice.³⁹ From this time on he was able to devote more time to the collection of materials for his book.

In an editorial exhortation to the physicians of the Mississippi Valley to publish the results of their observations, experience and experiments, he wrote:

*There is not in the 'wide world' a nobler and richer field for original Medical and Physiological observation, than our beloved West and South.*³⁹

The summer of 1842 found Drake making a careful survey of the north central states and of the Great Lakes. As a result of this trip he wrote one of his most beautifully descriptive essays: *The Northern Lakes, a Summer Resort for Invalids of the South*.⁴⁰ With a moving and artistic touch he pictured the lake region, methods and routes of travel, principal cities and scenic grandeur.

After a strenuous course of lectures during the 1842-43 session of The Louisville Medical Institute, Drake left by boat for New Orleans. From here he wrote on 17 February 1843:

38. Daniel Drake: *Traveling Memoranda, The Western J. of the Med. and Physical Sciences*, (Cincinnati) Second Hexade, Vol. IV:476, Oct., Nov., Dec. 1836.

39. Daniel Drake: [Editorial]—Contributions to our Journal by Societies. *The Western J. of Med. and Surg.* (Louisville), IV:75, July 1841.

40. Daniel Drake: *The Northern Lakes, a Summer Resort for Invalids of the South. The Western J. of Med. and Surg.* (Louisville), VI:401-426, December 1842.

34. *Ibid.*, p. 318-319.

35. *Ibid.*, p. 469-476, Oct., Nov. and Dec. 1836.

36. *Ibid.*, p. 474.

37. C. A. Van Arsdall: *A Medical History of Harrodsburg Springs. Bull. History of Med.*, (Baltimore, Md.), XXIII:387-418, July-August, 1949.

More than twenty years ago we announced the design of publishing a work on *Diseases of the West*. Of the causes which have delayed its preparation, we shall not speak in detail, and will mention one only. Reflection soon convinced us, that the undertaking was of greater magnitude and difficulty than it first appeared, and could not, indeed, be accomplished without extensive and patient personal observation in the north and south.

Our field of observation extends from Michigan to Florida, and from the western slopes of the Allegheny mountains, to Missouri, Arkansas, and Iowa.

Such is the enterprise on which we have entered at an advanced period of life, though with some of the activity and feeling which belong to earlier years. . . .⁴¹

Drake was still in New Orleans on 10 March 1843, and mentions in his letter of that date (a portion of which was reprinted in the *Boston Medical and Surgical Journal*⁴²) that he had auscultated the chest of the dying Seminole Chief, Tiger Tail, and heard "the palpitations of his savage but patriotic heart."⁴³ By the 30 March 1843, he had reached Pensacola, Florida, where he was impressed with its naval base.⁴⁴ He then wandered through the tributaries of the Mobile River and on up to Tuscaloosa, Alabama, where he visited the University and was "introduced to its respectable Faculty."⁴⁵ Everywhere he went the greatest hospitality was shown him. He was impressed with the harmony prevailing in the medical profession throughout the South with the exception of New Orleans.

Again the next year at the close of his lectures in The Louisville Medical Institute in the spring of 1844, Drake started southward. He wrote from Mobile on 23 April.⁴⁶ Next his itinerary carried him to New Orleans, thence into Indian Territory, Missouri, Illinois and on into the upper reaches of the Mississippi River,

whence he wrote on 11 October 1844.⁴⁷ By 16 October 1844, he was on a steamboat on the Ohio River, nearing home after a summer's journey of 6,200 miles.⁴⁸

The vacation periods of 1845 and 1846 Drake spent in Cincinnati, actively engaged in the composition of his book. He appears to have been extremely methodical in all he did—and equally indefatigable. He was described as

. . . seated at a large table, which was covered with opened volumes,—journals from every section of the country, and embryotic manuscripts in every stage of development, from skeleton field notes, up to the perfected copy ready for the hands of the compositor. . . .⁴⁹

The summer of 1847 sent Drake again assiduously seeking information in the field. This time it was on a trip through the mountains of West Virginia and Pennsylvania, into western New York and on to Quebec, Montreal and Toronto, which he reached early in September 1847.⁵⁰ Although he had a legion of correspondents all over lower Canada and the whole central valley, he was not content until he had made a personal investigation of the entire area. By the latter part of October 1847, he was back in Louisville to resume lectures. Since beginning his book he had travelled over 30,000 miles.

From the period immediately after his return to Louisville stems what has become a minor classic in its own right, although it has relatively little to do with things medical. During December 1847, Drake fell into a reminiscent mood, from which emerged a remarkable series of letters to his children, describing his boyhood and his preparation for the study of medicine. Eighteen years after his death, these letters were arranged and published under the title of *Pioneer Life in Kentucky*. This veritable gem of descriptive writing has passed through three editions, although its author never intended it for publication.⁵¹ Called "the greatest of all

47. *Ibid.*, N. S., II:545, Dec. 1844.

48. *Ibid.*, p. 547.

49. Thomas Wood: [Review of Drake: *Principal Diseases*. . .] *Western Lancet*, (Cincinnati), XV:685, November 1854.

50. Daniel Drake: *Traveling Letters from the Senior Editor*, No. 5. *The Western J. of Med. and Surg.*, N. S., VIII:455-461, November 1847.

51. Daniel Drake: *Pioneer Life in Kentucky*, Edited by Charles D. Drake, Cincinnati: Robert Clarke & Co., 1870. *Ibid.*, 1907. *Pioneer Life in Kentucky*, Edited from the original manuscript with introductory comments and a biographical sketch by Emmet F. Horine, New York: Henry Schuman, (1948.)

41. Daniel Drake: *Traveling Editorials*, *The Western J. of Med. and Surg.*, (Louisville), VII:235-240, March 1843.

42. Daniel Drake: *Diseases of the West*, *The Boston Med. and Surg. Journal*, XXVIII:308, May 17, 1843.

43. Daniel Drake: *Travelling Editorials*, *The Western J. of Med. and Surg.*, (Louisville), VII:315, April 1843.

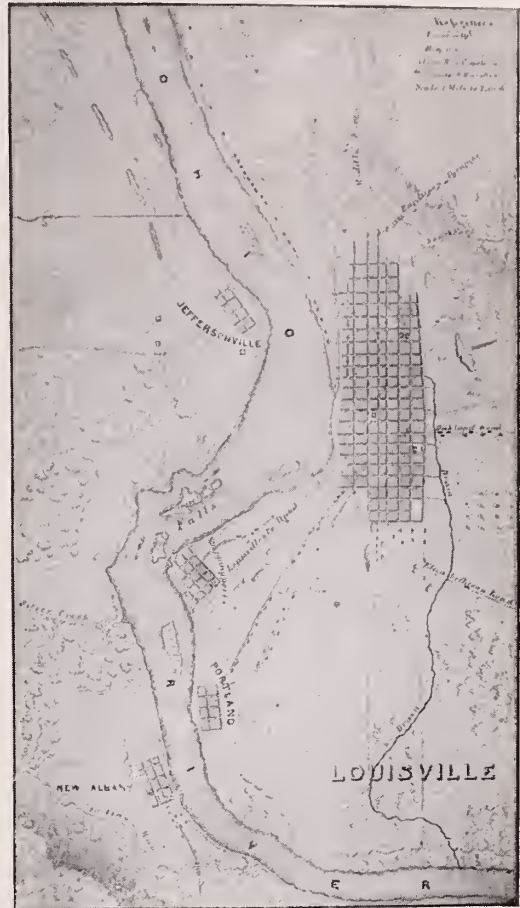
44. *Ibid.*, VII:393-400, May 1843.

45. *Ibid.*, VII:474, June 1843.

46. *Ibid.*, New Series, I:546, June 1844.

Kentucky books,⁵² it is a vivid portrayal of family, farm and social life in the then frontier settlement of Mayslick, Kentucky.

Meanwhile, composition of the first volume of his exceptional and enduring treatise on the *Diseases of the Interior Valley of North America* was resumed. Early in 1949 printing was started. After the 528th page had been printed, cholera struck Cincinnati and Drake lost several members of his family as well as many friends. He himself became ill from what he described as "a protracted attack of my old malady of the brain."⁵³ (My rhinological friends suggest that possibly Dr. Drake had occasional exacerbations of a severe sinusitis.) However, the manuscript was completed by 17 December 1849, and an application for copyright was made. The date of publication of the first volume of



LOUISVILLE, Ky., from the first volume of Drake's Classic (facing page 246.)

A
SYSTEMATIC TREATISE,
HISTORICAL, ETIOLOGICAL, AND PRACTICAL,
ON THE
PRINCIPAL DISEASES
OF THE

INTERIOR VALLEY OF NORTH AMERICA,
AS THEY APPEAR IN THE
CAUCASIAN, AFRICAN, INDIAN, AND ESQUIMAUX VARIETIES OF
ITS POPULATION.

BY DANIEL DRAKE, M. D.

CINCINNATI:
WINTHROP B. SMITH & CO., PUBLISHERS
PHILADELPHIA: GRIGG, ELLIOT & CO. •
NEW YORK: MARON & LAW.

1850.

52. J. Christian Bay: Settlers who Conquered the Frontier. *The Chicago Sun Book Week*, V:5, May 4, 1947.

53. Daniel Drake, A. L. S. from Cincinnati, Ohio, September 21, 1849 to Charles Wilkins Short, M. D., in the manuscript section of the author's Drake collection.

A Systematic Treatise. . . was 24 April 1850 when a copy was deposited in the Clerk's Office of the Ohio District.⁵⁴

The first volume alone comprised 894 pages. Published in Cincinnati, it contained four parts made up of sixteen, five, four, and eleven chapters respectively. The first part included a detailed analysis of the topographical and hydrographical features of the Valley. In addition to a folding frontispiece map of the area, there were seventeen full page plates showing various localities: Pensacola, Mobile, New Orleans, Montreal, Quebec and intermediate points. In the second part, the climate, variations in the barometric pressure, winds, rain, snow, humidity and electrical phenomena were carefully catalogued. In this part there were two plates and dozens of carefully prepared tables to elucidate the text.

54. Frederick R. Goff, Chief of Rare Books Division, The Library of Congress. Typed L. S. to author, June 9, 1947.

Preparation of the tables alone must have required a prodigious amount of labor. The third section dealt with diet and drinks, clothing, bathing, lodgings, shade trees, occupations, pursuits, exercise and recreations. The fourth section, which introduced febrile diseases, had been intended as the first part of the second volume and, as such, it was incorporated with additions in that volume, published posthumously at Philadelphia in 1854.⁵⁵

Hippocrates (460-370?) wrote, among many others, the celebrated treatise mentioned by Garrison (reference 5) in which the effects of climate and geographical situation upon health and upon character were presented in relation to racial groups. Drake's book is much more comprehensive in that a far greater number of factors including hygiene and sanitation are discussed. He conceived the vast Mississippi Valley with its marked diversity of physical and climatic features as a huge melting pot of the races in which diseases might be investigated from all possible angles.

Drake had been brought to Kentucky when the entire region was thinly populated and subject to Indian raids. He had observed the vast tide of immigration from Europe, the advent of steamboats and the rise of many large cities throughout the Valley. Pondering the effects on future generations, he wrote:

The world has not before witnessed such a commingling of races. . .

The Great Central Valley of North America is the last crucible into which living materials, in great and diversified streams, can be poured for amalgamation. . .⁵⁶

In passing, I must draw your attention to Drake's advanced ideas concerning the etiology of cholera and malaria. He asserted positively that the manner in which cholera spreads "was more fully explained by the animalcular hypothesis than by any other" although he added that vegetable germs might be responsible. With reference to malaria, when most physicians believed it due to marsh emanations, he taught that either animalcular or vegetable germs might be assumed as causes. He listed fourteen points in support of

these theories. He observed that the variable incidence of malaria from year to year was similar to the abundance of vegetable or insect forms one year and their scarcity in others years. To quote:

*It has often happened that musquitoes have been absent from the banks of the middle portion of the Ohio river, for a year, and in the next appeared in immense numbers. We have but to suppose insect forms of paralled size, to live under corresponding laws, and the hypothesis now before us, offers an explanation of sickly and healthy seasons.*⁵⁸

Not only was the book based on the widest possible original investigations but it represented the most advanced American thought of the period. It was not surprising that the work was enthusiastically received in the United States and in Europe. Dr. David Condie (1796-1875), well known Philadelphia author, praised it through twelve pages of the *American Journal of the Medical Sciences*, of which the following is an extract:

*We hail with pleasure the appearance of this long expected work of Dr. Drake, on the medical topography and diseases of the valley of the Mississippi. Our anticipations in relation to it, founded upon the known abilities and untiring industry of the author, and the time and labour he is known to have devoted to the collection of the materials required for its successful execution, have always been in the highest degree favorable. These anticipations have not been in the least disappointed, now that the work has appeared. It will, we are convinced, be ranked as the most valuable and important original production, of a strictly professional character, that has yet appeared from the pen of any of our physicians. . . No American physician will consider his library complete without a copy of the work of Dr. Drake.*⁵⁹

Dr. J. V. C. Smith (1800-1879), the versatile editor of *The Boston Medical and Surgical Journal*, wrote:

. . . The embodying of the medical topography, hydrology, geology, etc., of its interior valley, including the

55. Daniel Drake: *A Systematic Treatise*. . . Edited by S. Hanbury Smith and Francis G. Smith. Second Series. Philadelphia: Lippincott, Grambo & Co., 1854.

56. *Ibid.*, Vol. I: 647.

57. *Ibid.*, pages 723-727.

58. *Ibid.*, pages 726-727.

59. [Review by David F. Condie.] *American J. Med. Sciences*. (Philadelphia, Pa.), N. S., XX:109-120, July 1850.

principal diseases incident to its climate, is an undertaking of great labor, which few would possess the hardihood to undertake, and still fewer have the happy faculty of rendering such researches interesting, instructive and practical. The profession are much indebted to Dr. Drake for his indefatigable exertions in producing a work of such magnitude and importance. . .⁶⁰

Other American reviews were equally laudatory.^{61. 62. 63}

Shortly after the publication of the first volume, the American Medical Association held its annual meeting in Cincinnati. Drake received an ovation after Dr. Alfred Stille (1813-1900) read the report on recent medical literature in which he stated:

[Dr. Drake's work] belongs to the very highest rank of our medical literature, and may very probably come to be regarded as the most valuable original work yet published in America. . . Its distinguished author has raised a durable monument to his own name, and to the medical reputation, not only of the Great Valley, but to the greater Union. . .⁶⁴

The first review in a foreign periodical appeared in November 1850 in the *Monthly Journal of Medical Science*, published in Edinburgh:

This is a very remarkable volume, constituting perhaps the most extensive and able work on medical topography that has ever issued from the press. A description of diseases peculiar to the tract of country beginning with the tropics and terminating with the polar circle, having an area of six million square miles and inhabited by numerous races of men, may well be considered a gigantic undertaking. Yet long journeys of observation, during a period of forty years, and personal examination car-

ried through eighteen degrees of latitude and nearly as many of longitude, have enabled the author to publish the present work.

The contents of the book are so varied and extensive as to defy analysis. . .

To the medical practitioners of the region described, Dr. Drake's labours will prove invaluable. . .⁶⁵

The *British and Foreign Medico-Chirurgical Review* (London) devoted thirty pages to summarizing Drake's book which was called "an elaborate work." Extracts were quoted to "exhibit not only the extreme care and minute detail with which the topography and medical history of each place is given, but also the very important information which is profusely scattered through the whole work. . . [It] would do honor to any country. . ."⁶⁶

No French reviews have so far been located; but two laudatory ones in German have been found. The earlier one, by the well known geographer and journalist, Dr. Karl Andree (1808-1875), did not attempt an appraisal of the work but merely gave a digest of its contents.⁶⁷ The later review, by Dr. Joseph Finger, author and prominent physician in Prague, devoted twenty-five pages to a careful analysis and appraisal of the first volume.⁶⁸ He emphasized the need for such works and praised Drake's industry in having personally investigated so much of the vast Mississippi Valley. Attention was rightly called to the paucity of autopsies, a lack which Drake himself deplored. In conclusion, Finger stated:

. . . that the general practitioner in America, for whom the [work] is in fact written, may find therein without doubt much useful instruction, and that it contains much interesting information for the European physician.—The first section appears to us in any case the better part of the work, wherein the subjects are discussed with much accuracy; only it is surprising, that the author after the ample appreciation which he bestows

60. [J. V. C. Smith, Editor] *The Boston Med. and Surg. J.*, XLII:357-358, May 29, 1850.

61. S. S. Purple: Review, *The New York J. of Med. and the Collateral Sciences*, N. S., V:94-95, July 1850.

62. Lunsford P. Yandell: Review of "A Systematic Treatise. . . *The Western J. of Med. and Surg.*, 3d Series, VI:228-256, (Sept.), 350-360, (October), and 408-438, November 1850.

63. Austin Flint: [Review]: A Systematic Treatise. . . 1850. *Buffalo Med. J.* (Buffalo, N. Y.), VI:62-64, June 1850.

64. Alfred Stille, Chairman: Report of the Standing Committee on Medical Literature, A.M.A., Cincinnati Meeting, May 1850. Philadelphia: T. K. & P. G. Collins, 1850, page 16. In the *Transactions of A.M.A.*, Vol. III: 166.

65. [Review] *Monthly J. of Med. Science* (Edinburgh), XI:442-443, November 1850.

66. [Review] *The British and Foreign Medico-Chirurgical Review* (London), VII:302-332, April 1851.

67. [Dr. Karl Andree]: Das innere Thalbecken von Nordamerika. *Das Westland* (Bremen), I:199-208, 1852.

68. Dr. [Joseph] Finger: [Review in] *Vierteljahrsschrift fuer die praktische Heilkunde* (med. Facultæt in Prag), XI Jahrgang, 1854, 1st Bd., Literaerischer Angelegen Section: 27-52.

on the physical conditions and their laws of action nevertheless persists in so erroneous and for the greater part teleological conception of nature as so many of the opinions clearly show.⁶⁹ [Translation mine.]

Work on the second volume continued apace but late in 1850, Drake turned aside to another subject—slavery—which for many years had been a topic of major interest to him. He viewed with alarm the growing discord between North and South which he believed would undoubtedly lead to dissolution of the Union, even to civil strife. Drake deplored slavery and advocated gradual emancipation and colonization in Africa, for which he suggested feasible plans. He strongly disapproved of the actions of the rabid abolitionists. As a result of their tactics, he discerned a steady worsening of the situation. To stem its tide, humanitarian that he was, he wrote a series of three letters addressed to Dr. John C. Warren (1778-1856), the Bostonian of ether fame, then President of the American Medical Association. These were published in *The National Intelligencer* (Washington) in April 1851,⁷⁰ and reprinted in book form in 1940.⁷¹

These communications, with clear logic based on personal observations throughout the South, showed that the condition of the slaves was constantly improving. Granting that the discord between North and South was basically economic, slavery was the firebrand which inflamed emotions. Drake recognized this. In Ohio, where the abolitionists were extremely active and where Harriet Beecher Stowe obtained many of the stories gruesomely dramatized in *Uncle Tom's Cabin*, Drake with philosophical objectivity wrote:

Many a desirable and proper end is lost by impatience of excited feeling. We should realize that great changes cannot be accomplished in a moment; and that all important national reforms, to be harmless and permanent, must be made slowly. It is sufficient to know that they are in progress—to perceive that the causes that are in operation are of the right kind, and not

*temporary in their duration; all of which is, obviously, true of those to which I have referred. Again, therefore, I say, let us rely on those causes for the immediate and ultimate relief of the slave, and not attempt, unauthorized either by God or man to cut asunder his fetters; or by irritating, without controlling his master, to retard their falling off.*⁷²

It is possible that had the plans advocated in Drake's *Letters* been carried out, the Civil War might have been averted as well as many of the racial problems which plague us today.

During Drake's brief illness before his death on 5 November 1852, the thought of his unfinished work troubled him.⁷³ The fondest desire of his heart had been to complete the second volume. Fortunately the manuscript consisting of three thousand pages required only editing. This was undertaken by Drs. S. Hanbury Smith (1810-1894) of Columbus, Ohio, and Francis G. Smith (1818-1878) of Philadelphia, who completed the task in time for publication within two years of Drake's death.⁷⁴

The American and foreign reviews from which extracts have been made clearly show the high regard of contemporaries for Drake and his book. Moreover, it was not only in reviews that the praises of Drake's work were sung. Both at home and abroad in circles which were inclined at that time to be skeptical of American scientific ability, Drake's book was a much quoted reference. August Hirsch (1817-1894), Professor of Medicine in the University of Berlin, in his *Handbook of Geographical and Historical Pathology*, refers to Drake's classic forty-five times in addition to using four quotations from it.⁷⁵

Despite the enthusiastic reception by eminent physicians and the favorable reviews of Drake's book not enough copies were sold to defray the costs. Although it "fell stillborn from the press," Dr. Samuel D. Gross rightly stated: "... the work will in the future, I have no doubt, shed

69. *Ibid.*, p. 52.

70. Daniel Drake: Letters on Slavery (to Dr. John C. Warren, Boston), *National Intelligencer* (Washington), Vol. LII, April 3, 5, 8, 1851.

71. Daniel Drake: *Letters on Slavery to Dr. John C. Warren*, Reprinted. . . with an introduction by Emmet Field Horine, New York: Schuman's, 1940.

72. *Ibid.*, p. 9.

73. Alexander H. McGuffey: *Particulars Concerning Last Illness and Death of Daniel Drake, M. D. M.*, in Library of Historical and Philosophical Society of Ohio, Cincinnati.

74. Daniel Drake: *A Systematic Treatise. . . 2d Series*. Philadelphia: Lippincott Grambo & Co., 1854.

75. August Hirsch: *Handbook of Geographical and Historical Pathology*, Translated by Charles Creighton, 3 vols. London: The New Sydenham Society, 1883.

lustre upon medical literature and confer an enviable immortality upon the name of its author."⁷⁶

In closing, we may ask ourselves how we should appraise Drake's work today—one hundred and one years after its publication. As we leaf through the nineteen hundred pages, study the interesting maps and precise tables, we cannot but marvel that such a monumental and original medical work could have been written by one whose formal education was so rudimentary. We cannot fail to observe the breadth of mind which conceived diseases as a phase of natural history to be studied against the background of environment. We are amazed at the fortitude of a man who in his sixth decade personally investigated, despite primitive modes of travel, more than a third of the total area of the United States and a large part of Canada. A keen and philosophical spirit set a goal which, after forty years of unremitting toil, was reached amid the applause of his confreres. This work, "one

of the greatest masterpieces of medico-geographic research,"⁷⁷ continues to be prized and consulted by the student of social history as well as by the historian of medicine. Thus it would seem that the prophecy made in 1876 by John Shaw Billings (1838-1913), father of the Army Medical Library and its superb *Index Catalogue*, has been fulfilled in less than the allotted time:

... This work is the 'Magnum Opus,' and results of the life-long labour, including extensive personal observation, literary research, and matured reflection, of a man whose fame, as compared with that of his contemporaries, will probably be greater a century hence than it is today, and whose name, even now, should be among the first on the list of the illustrious dead of the medical profession of the United States. . .⁷⁸

77. Henry E. Sigerist: *American Medicine*. New York: W. W. Norton & Co., (1934), p. 93.

78. John S. Billings: *A Century of American Medicine—Literature and Institutions. The American J. of Med. Sciences* (Philadelphia). Vol. 144 (New Series): 439-480, October 1876.

76. Samuel D. Gross: *Autobiography*. 2 vols. Philadelphia; George Barrie, 1887, Vol. II:269-270.

Medical Relationships in Industrial Health

J. F. McCAHAN, M. D.

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Rochester, N. Y.

The American Medical Association's interest in industrial health extends over a considerable period of years and has not been confined to the clinical management of the industrially disabled. It has invaded the closely related fields of medical economics, public relations and social legislation.

In July, 1937, the House of Delegates accepted the recommendation of the Board of Trustees that a Council on Industrial Health be created as a committee of the Board.

The Council membership consists of twelve active and six ex-officio members. The active membership represents men who have demonstrated accomplishments and broad understanding in the fields of industrial medicine, surgery and hygiene and with ability to provide as great a de-

gree of integration as possible with the official agencies and medical specialties most concerned. The ex-officio appointments are representative of organizations or agencies, with which the Council works closely in the formulation of policy, procedures and projects. The Council staff is capably directed by Dr. Carl M. Peterson, Secretary, who has served in this capacity since the beginning.

The record of the Council on Industrial Health has been one of gradual expansion of function, of growing realization of the vast scope of industrial health and welfare, and of sharpened focus on those medical relationships which stand out as of fundamental importance. Emphasis has been placed on four major activities which the Council believes must be energetically pursued if industrial health education and services are to spread and if medical standards in this field are to improve. These are:

Presented at the Centennial Meeting of the Kentucky State Medical Association at Louisville, October 2, 1951.

1. The creation of public interest and demand.
2. The clarification of industrial health objectives.
3. Improved professional training and standards.
4. Better medical organization for industrial health on the part of individual physicians and medical societies.

Public interest deals particularly with management and labor. Good contacts have been established with the major trade and management associations and chambers of commerce, all of whom have been concerned with the expanding character of occupational health and more particularly its extension to the employees of small plants. Joint action has been taken with labor and management in the elaboration of industrial physical examination standards, with many aspects of workmen's compensation coverage, and more recently with labor-management cooperation for improved industrial health and safety. Other public relations activity has dealt with the place which industrial health and hygiene should occupy at international, inter-American, federal and state levels.

Better service to industry depends on professional education and organization, both of which have been regarded as primary obligations of the Council. All of the available avenues for improvement have been used. Medical schools have been repeatedly urged to acquaint their undergraduates with the essentials of occupational health, and with tolerable success. Introductory and refresher courses have been conducted by medical schools and medical societies, frequently as joint enterprises. The active cooperation of the Council on Medical Education and Hospitals has been enlisted for guidance in all educational activities, and particularly to determine the desirability of embarking upon a specialty certification program. During the past year positive steps have been taken by the joint action of the Industrial Medical Association, the American Academy of Occupational Medicine and the Section on Preventive and Industrial Medicine and Public Health of the American Medical Association to create an American Board of Occupational Medicine. Although the Council has had no direct responsibility in this development, a number of its members have served in the organizational activity.

In 1940 and 1941, the first efforts to develop interest through the specialty groups were begun, using the Section on Dermatology and Syphilology as a pattern and stimulus. All specialty groups having direct relationship with industrial medical services have appointed liaison committees and the work accomplished by them has been one of the most valuable and fruitful phases of the Council's educational and organizational program. Nurses, hygienists, dentists and engineers have almost identical problems to solve and it has been the policy of the Council to work closely with these professional groups.

It became evident that a major goal of the Council was the formulation of a program that would motivate and guide the development of industrial health service and education at the community level. To further these efforts and for many other purposes, it was highly essential to develop proper cooperative agencies in state and local medical societies. These committees have been of great usefulness and the encouragement which they have given to the industrial health movement has been invaluable. A joint conference of the Council and Chairmen of the State Committees on Industrial Health was held during the Annual Congress on Industrial Health this past February. It was designed to acquaint the Council and the state committees with the work of each other and to effect improved teamwork. Attention was focused on strategy for the acceleration of the development of industrial health services in accordance with accepted standards and with emphasis on local development. The results of this conference were so satisfactory that it is intended to make this meeting an annual event.

In May, 1950, the American Academy of General Practice reported that 94 per cent of its membership cared for industrial cases, the average number of cases seen in 1948 was 234 per member, and about 20% of its members devote full time to industrial practice. In consequence, representatives of the Academy and of the Section on General Practice of the American Medical Association were invited to meet with the council to discuss a program of training for general practitioners in the fundamentals of industrial medical practice. A joint committee was established to formulate a plan of action. A program and curriculum have been prepared and

submitted to the interested groups for further study and adoption. It is anticipated that the curriculum will be used in the postgraduate educational activities of the American Academy of General Practice. The Council will be expected to prepare a list of qualified speakers and teachers for the furtherance of this training program.

During the past year the Council has been engaged in a number of other projects covering a wide area of interests including civil defense, manpower mobilization, safety, first aid, noise, the older worker, chronic illness, human relations, atmospheric pollution and environmental hygiene. Through our reprint service, published reports which result from many of these projects are made available to interested individuals upon request. The monthly Newsletter serves as a medium for exchange of information and to promote education and services. The mailing list of three hundred includes the chairmen of the state Committees on industrial health, state medical society

executives, state health and hygiene personnel, as well as the official headquarters group. It is also published in the Archives of Industrial Hygiene and Occupational Medicine, as a means for wider distribution.

Medical relations in workmen's compensation have occupied the attention of the Council from its inception. Its range of interest includes effective relations with state medical societies, specialist organizations, with industrial commissions and compensation boards, and with the casualty and liability insurance companies.

It is confidently expected that through these means, administrative standards will be considerably improved and that great advances can be made in the simplification of report forms, uniform statistical methods, medical testimony, disability evaluation and rehabilitation.

The Council on Industrial Health, confronted with a host of unsolved problems in the field of industrial health and welfare, rightly believes its career of useful activity has barely started.

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COMMITTEE HANDLING GRIEVANCES PASSES SECOND MILESTONE

The Professional Relations Committee passes its second birthday this month. It was activated by the Council at its December 29, 1949 meeting and organized in February of 1950. This group has been one of the Association's most active committees.

The committee, first known as the Grievance Committee, is made up of the immediate five living past presidents. The member who has been retired from the Presidency for the most number of years is automatically the chairman. The Council changed the name of the committee from Grievance to Professional Relations about a year ago at the request of the committee.

While the chairman of the committee adjudicates a number of the complaints by mail it is still necessary for the committee to meet frequently. As the meetings enjoy almost perfect attendance, it

is not uncommon for its members to give more than a total of five days and some 1,450 miles of travel to each meeting.

The committee has received a number of complimentary letters from both patients and physicians, but for the most part the nature of the work is difficult, time-consuming, sometimes unpleasant and always delicate. The committee has no authority to take punitive action, and so far has not found it necessary to recommend such measures to the Council.

The vast percentage of the cases deal with alleged overcharging. Failure on the part of the physician to explain his charges often results in misunderstanding and ill will. There are a few cases growing out of failure to go when called, rough language and allegations that bills were sent when no services were rendered. The committee receives no complaints orally and urges that all grievances be submitted to it in typewritten form.

This committee never "ducks" an issue or "whitewashes" the acts of a fellow practitioner. Because of its excellent unselfish service we can all be justly

proud of its work. There is no way to measure the contribution this committee has made to both the profession and people of this state.

THE WHOLESOME TREND TOWARD GENERAL PRACTICE

The increasing trend of medical school graduates toward general practice is quite evident and indicates that the pendulum is swinging from the era of over-specialization. This is a most healthy situation and should be encouraged. It is due to several reasons, not the least of which is the greater respect that is commanded within the profession by today's general practitioner, due to his increased knowledge and training. Vastly improved facilities for general practice, more equitable remuneration, and the removal of his office from the crossroads to county seats and other centers of population in the counties where there are modern hospital facilities and improved living conditions have also played their part in the current transition.

The effect upon the practice of medicine is wholesome. Dr. Paul Williamson, who is associated with the University of Tennessee's extensive training program for general practice, stated in a recent communication that an unofficial survey showed that less than 20% of Memphis' specialists find it economically possible to

remain strictly within the bounds of their specialty but, due to economic pressure, resort to treating the commonplace diseases in and related to their specialties. Dr. Williamson thinks that most physicians will agree that a man with intelligence and fortitude enough to become an expert in a specialty field is entitled to enough work to keep him busy without invading the field of the general practitioner.

Realization of the need for more general practitioners has resulted in a change in many medical training centers that seems to indicate that the basis of undergraduate medical training will be instruction in general practice achieved by the specialist and the general practitioner working together.

Dr. Williamson warns that care must be taken not to permit the pendulum to swing too far in its present direction since there is an ideal balance between the general practitioner and his specialized colleague which should be struck and maintained.

V. A. BANS PRESCRIPTION OF ALCOHOLIC BEVERAGES

Dr. O. P. Miller, Chief Medical Officer of the Louisville Veterans Administration Regional Office, has been requested to advise all V. A. fee basis physicians that V. A. does not approve the prescription of alcoholic beverages in connection with outpatient treatment of veterans. He was informed that since other suitable recognized therapeutic agents are available,

whiskey and other alcoholic beverages are not considered appropriate for prescription.

Pharmaceutical associations were advised not to accept such prescriptions after January 15, 1952, but prescriptions that were accepted and filled in good faith before that date may be processed for payment.

President's Page

The doctors of Kentucky are fortunate in having chosen a profession which is generally recognized by the public as being the one profession qualified to render complete service as a healing art.

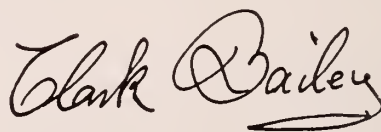
Although the government would socialize us it pays us the respect of admitting that our profession is essential. Labor, industry, the military, and even the socialists do not question our qualifications to render competent service. No greater compliment could be given our profession of medicine than the recognition of our being well qualified and essential by those who oppose us and by those who attempt to control us. That opinion is the result of growth, progress, vision, and tireless effort on the part of our profession.

There are other professions of the healing arts that are not qualified by training to render a broad medical service. Yet they practice in our own state and are usually very active at Frankfort at each session of the Legislature in attempting to pass laws which give them wider

privileges of practice without going through what we consider proper training to render that service. Their dues are many times the amount of our dues. Their special assessments for the purpose of influencing legislation are high. They are especially commendable for their unity and loyalty.

Your Legislative Committee and the Council and officers of the Kentucky State Medical Association are wide awake and active. They will need your active support and your loyalty during the ensuing session of the Legislature. There will be bills introduced which we must support—Some we must oppose. You will be kept informed of their relative importance.

If every member of our profession in Kentucky will pay his dues now and cooperate with our constructive program we need have no fear of losing that right to serve which we so richly deserve. Pay your dues now. Contact the officers of your local and state society and offer your cooperation. Give them your loyalty.



PRESIDENT

ORGANIZATION SECTION

"Office Gynecology" Is Subject of March 18 Telephone Seminar

The second telephone seminar broadcast will cover "Office Gynecology—Panel Discussion on Vaginal Discharge and Bleeding," Herbert L. Clay, M. D., Director of P. G. Refresher Training at the University of Louisville School of Medicine, announced.

This session, to be held March 18 at 7:30 P. M., Central Standard Time, Dr. Clay said, will be moderated by Richard R. Slucher, M. D., Clinical Associate in Medicine. Members of the panel will be Laman A. Gray, M. D., Associate Professor of Obstetrics and Gynecology; W. O. Johnson, M. D., Professor and Chairman of Department of Obstetrics and Gynecology; and Robert F. Monroe, M. D., Associate Clinical Professor of Obstetrics and Gynecology.

The first seminar broadcast is scheduled for February 26. "Management of the Patient with Jaundice" is the subject that will be discussed. Walter S. Coe, M. D., Louisville, will moderate this session and other participants are Marion F. Beard, M. D., William M. Christopherson, M. D., and George B. Sanders, M. D.

Of particular interest to members of the county medical societies subscribing to these courses are the manuals which the Medical School will send them about ten days before the course. The first purpose of this manual is to allow the doctor to review it and submit questions to the University which would be answered on the latter part of the broadcast.

The second use of the manual will be found as the program unfolds. Those attending will follow the outlined and liberally illustrated manual as the program progresses. The situation will be very much as though he was sitting in a darkened meeting room listening to a lecture illustrated with slides.

The details of the April 22 broadcast, which will be the third and final this season, will be announced in the March issue of the Journal.

These postgraduate instructional broadcasts are sponsored by the Kentucky State Medical Association in cooperation with the University of Louisville School of Medicine. They are staged under the general supervision of the Association's Committee on Medical Education, of which Robert Lich, Jr., M. D., is Chairman.

There is still time for county societies to make arrangements for the last two broadcasts, Dr. Lich said.

Council Asks Counties Consider Associate DDS Membership

County medical societies that make no provision for dentists to be associate members, were asked by the Council at its December 27 meeting to consider changing their by-laws, making it possible to accept dentists as associate members.

The K.S.M.A. By-Laws have this provision as do many county medical societies. The Executive Committee and the Council both went on record as being in favor of providing for associate membership for dentists by all counties.

The associate member receives an annual subscription to the Journal of the Association and may be granted the privilege of the floor in the scientific assembly. Associate members may not hold office or vote.

Next Annual Meeting, Oct. 7-9, 1952 To Honor Daniel Drake

The 1952 annual meeting of the Kentucky State Medical Association will be held in Louisville October 7, 8 and 9, and will be dedicated to the memory of Daniel Drake, M. D., one of the first honorary members of the Kentucky State Medical Association.

The "Daniel Drake Meeting" was authorized by the Council which granted the request of Clark Bailey, M. D., Harlan, President of the Association, who asked that the 1952 meeting be in commemoration of the renowned, pioneer physician.

Dr. Drake, one of the best known medical teachers, authors and editors in the second quarter of the nineteenth century, was the first man to be elected as an honorary member of the Kentucky Medical Association, this being done at the 1852 Annual Meeting. He was nominated by Samuel D. Gross, M. D., professor of surgery at the Louisville Medical Institute.

Born in 1775 in New Jersey, Dr. Drake came to Kentucky with his family when he was less

than 3 years of age. He held a professorship at the Louisville Medical Institute from 1839 to 1849 and from 1850 to 1852.

Dr. O'Nan Discusses Rural Health With Farm Bureau Group

Walter L. O'Nan, M. D., Henderson, Chairman of the Committee on Rural Health of the K.S.M.A., spoke at a meeting of the Rural Medical Care Committee of the Kentucky Farm Bureau Federation during the recent annual meeting of the Federation in Louisville.

Dr. O'Nan outlined the broad objectives of the rural health movement. He discussed the operation of the Rural Medical Scholarship Fund, and told how the Physicians Placement Bureau, operated by the State Department of Health with the cooperation of the K.S.M.A., functioned.

Pointing out community health was a community responsibility, Dr. O'Nan told how rural health councils could aid in improving the health of the community.

Ed Reddick, M. D., Louisville, Deputy Health Commissioner, spoke on some of the greatest hazards today to rural community health.

Diabetes Committee Makes Report On Detection Drive

Incomplete returns show the Diabetic Detection Drive, sponsored in November by the K.S.M.A., developed 207 positive tests and 74 proved diabetics, Carlisle Morse, M. D., Louisville, Chairman of the Association's Diabetes Committee, stated.

"Despite the fact that the limited time we had in which to promote this drive did not allow for adequately acquainting our membership and the public with the nature and purpose of it," Dr. Morse said. "We are highly pleased with the results and we want to thank all who participated in the effort."

It was indicated that a second diabetic detection campaign would be conducted this fall in cooperation with the American Diabetes Association.

Other members of the 1951-52 Diabetes Committee are: George N. Burger, M. D., Covington; Frank H. Moore, M. D., Bowling Green; Herald K. Bailey, M. D., Ashland; Franklin B. Moosnick, M. D., Lexington; Luther Bach, M. D., Newport; William P. Hall, M. D., Paducah; William R. Parks, M. D., Harlan; and Guinn S. Cost, M. D., Hopkinsville.

A.A.G.P. President, Secretary To Speak At April 30 Luncheon

R. B. Robins, M. D., Camden, Arkansas, President of the American Academy of General Practice, will be a luncheon speaker at the day-long session of the Kentucky Chapter, April 30, at the Kentucky Hotel in Louisville, R. R. Slucher, M. D., Buechel, announced.

Mr. Mac F. Cahal, Kansas City, Executive Secretary of the A.A.G.P., will share the luncheon spotlight with Dr. Robins, Dr. Slucher, President of the Kentucky Chapter of the Academy, said. Attending physicians and their wives are invited.

"Intestinal Obstruction" will be discussed by Phil Thorek, M. D., Chicago. Four other guest speakers will present scientific papers at this session to which all K.S.M.A. members are invited. The complete program will soon be announced.

Executive Committee Resolution Gets A.M.A. Action

A resolution, asking the A.M.A. to rescind its ruling covering the payment of 1950 dues before accepting dues any subsequent year, was authorized by the Executive Committee of the Council.

The resolution was presented at the Los Angeles Meeting of the A.M.A. House of Delegates December 4-7, by J. Duffy Hancock, M. D., Louisville, a K.S.M.A. Delegate. The Executive Committee's resolution follows:

"WHEREAS, The American Medical Association has distinguished itself as a guardian of the health and medical welfare of the people and has demonstrated its vigor and effectiveness in the battle against compulsory insurance; and

"WHEREAS, It is most desirable that the American Medical Association not only maintain but increase its capacity to carry on the battle against disease, quackery and socialism; and

"WHEREAS, Its policy of requiring all members of state medical associations up to and including 1950 to pay 1950 American Medical Association dues of \$25.00 before being able to join the American Medical Association in 1951 or any subsequent year arouses resentment on the part of some of the members and has a tendency to reduce its usefulness; and

"WHEREAS, This policy not only creates antagonism for the American Medical Association but also generates ill feeling for the state

association officers who attempt to collect back American Medical Association dues; and

"WHEREAS, This policy is creating much additional and unnecessary work and correspondence for the state medical association officers; therefore, be it

"RESOLVED, That the House of Delegates rescind its action and allow and encourage all members in good standing of state medical associations before or during 1950 who did not pay American Medical Association dues in 1950 to join the American Medical Association in 1951 or subsequent years without penalty or prejudice."

At the December 27 meeting of the Council, Dr. Hancock reported considerable interest in and discussion on the subject in the reference committee hearing and on the floor of the House. The Kentucky Delegate said that a blanket remission would cause further confusion and discontent. The following substitute resolution was passed, according to the official digest of proceedings:

"RESOLVED, That the House of Delegates give to the Secretary of the American Medical Association the authority to negotiate with each state organization separately as to the method of correcting misunderstandings which exist relative to the collection of 1950 dues only."

New State Committees For 1951-52 Announced

The 1951-52 K.S.M.A. committee appointments, which are named by the President or Council as provided in the By-Laws, are almost complete and are listed below. A number of the committees were appointed soon after the annual meeting and some have been working. (Asterisk preceding the name of the committee indicates it was appointed by the Council.)

STANDING COMMITTEES

Committee on Arrangements

R. Haynes Barr, Owensboro, Chairman
Joseph C. Bell, Louisville
Charles M. Edelen, Louisville
William H. Pennington, Lexington
Keith Smith, Corbin

Committee on Scientific Assembly

Clark Bailey, Harlan, Chairman
R. Haynes Barr, Owensboro
T. O. Meredith, Harrodsburg, 2 years (term expires 1953)
Morris Flexner, Louisville, 1 year (term expires 1952)
Bruce Underwood, Louisville, Secretary

*Public Relations Committee

R. Haynes Barr, Owensboro, Chairman, 1 year (term expires 1952)
Glenn Bryant, Louisville, 1 year (term expires 1952)
David Cox, Louisville, 2 years, (term expires 1953)
William Pennington, Lexington, 2 years (term expires 1953)
Edward Wilson, Jr., Pineville, 3 years (term expires 1954)

*Committee on Medical Service

G. L. Simpson, Greenville, Chairman, 3 years (term expires 1954)
Alfred Miller, Louisville, 3 years (term expires 1954)
John E. Haynes, Dawson Springs, 2 years (term expires 1953)
Walter Cawood, Harlan, 2 years (term expires 1953)
Cy Waldrop, Williamstown, 1 year (term expires 1952)

Committee to Study the Constitution and By-Laws

Guy Aud, Louisville, Chairman
R. Haynes Barr, Owensboro
Charles B. Stacy, Pineville
Hugh L. Houston, Murray
Bruce Underwood, Louisville

Medico-Legal Committee

J. B. Lukins, Louisville, Chairman
Woodford B. Troutman, Louisville, Ex-Officio
Bruce Underwood, Louisville, Ex-Officio
Clark Bailey, Harlan, Consultant
Lanier Lukins, Louisville, Consultant

SPECIAL COMMITTEES

Kentucky Committee for Contributions to American Medical Education Foundation

J. Duffy Hancock, Louisville, Chairman
Howell J. Davis, Owensboro
J. Gant Gaither, Hopkinsville
Charles F. Long, Elizabethtown
M. J. Henry, Louisville
Sam A. Overstreet, Louisville
Winfrey P. Blackburn, Frankfort
Harold Parker, Maysville
William H. Pennington, Lexington
Edward H. Ray, Lexington
Wendell V. Lyon, Ashland

Diabetes Committee

Carlisle Morse, Louisville, Chairman
George N. Burger, Covington
Frank H. Moore, Bowling Green
Herald K. Bailey, Ashland
Franklin B. Moosnick, Lexington
Luther Bach, Newport
William P. Hall, Paducah

William R. Parks, Harlan
Guinn S. Cost, Hopkinsville

***Advisory Committee to the Editor**

Guy Aud, Louisville, Chairman
Richard J. Rust, Newport
James E. Hix, Owensboro

***Education Campaign Committee**

W. Vinson Pierce, Covington, Chairman
(Other members to be appointed at a later date)

Committee on Emergency Medical Service

Guthrie Y. Graves, Bowling Green, Chairman
Thomas Van Zandt Gudex, Louisville
Orion L. Higdon, Paducah
Leland E. Payton, Lynch
W. Mountjoy Savage, Maysville
John S. Sprague, Lexington

Committee on Hospitals

Samuel H. Flowers, Middlesboro, Chairman
Charles B. Johnson, Russell
John P. Glenn, Russellville
E. S. Dunham, Edmonton
Joseph C. Bell, Louisville
B. Earl Caywood, Danville
Rankin C. Blount, Lexington

Kentucky State Advisory Committee to Selective Service

A. Clayton McCarty, Louisville, Chairman
J. Duffy Hancock, Louisville, Vice-Chairman
Charles B. Billington, Paducah
Glenn U. Dorroh, Lexington
R. Arnold Griswold, Louisville
L. O. Toomey, Bowling Green
John L. Walker, D. D. S., Louisville, Sub-Chairman
Frank W. Jordan, D. D. S., Louisville
E. C. Hume, D. D. S., Louisville

K.S.M.A. Dental Committee

Thomas J. Crume, Owensboro, Chairman
Millard C. Loy, Columbia
Henry V. Johnson, Georgetown
Allen L. Cornish, Lexington
R. Ward Bushart, Fulton

K.S.M.A. Pharmacy Committee

Ben H. Hollis, Louisville, Chairman
Thornton W. Scott, Lexington
W. Keith Crume, Bardstown
Hugh L. Houston, Murray
Thomas P. Leonard, Frankfort

***Legislative Committee**

Hugh L. Houston, Murray, Chairman
B. B. Baughman, Frankfort, Co-Chairman
Rufus C. Alley, Lexington
Guy Aud, Louisville
Clark Bailey, Harlan
R. Haynes Barr, Owensboro
Clyde C. Sparks, Ashland
Charles B. Stacy, Pineville

Charles B. Wathen, Owensboro
Billy K. Keller, Louisville
Norman Adair, Covington

Board of Directors of McDowell Memorial Foundation

Charles A. Vance, Lexington, Chairman
Russell Starr, Glasgow
E. M. Howard, Harlan
George McClure, Danville
Laman A. Gray, Louisville
Emil Novak, Baltimore, Maryland
Thomas Meredith, Harrodsburg
Irvin Abell, Louisville
Orion L. Higdon, Paducah

Committee on Medical Education

Robert Lich, Jr., Louisville, Chairman
D. G. Miller, Jr., Morgantown
Lawrence T. Minish, Louisville
J. R. Gott, Louisville
Herbert L. Clay, Jr., Louisville

Special Committee on Medical Education

Sam A. Overstreet, Louisville, Chairman
J. Murray Kinsman, Louisville
Bruce Underwood, Louisville

Medical Practice Committee

J. B. Lukins, Louisville, Chairman
G. L. Simpson, Greenville
Samuel H. Flowers, Middlesboro
Carl H. Fortune, Lexington
Walter Lee Cawood, Harlan
Vincent Goodlet, Frankfort

Medical School Advisory Committee

Karl Winter, Louisville, 1 year, Chairman
C. C. Howard, Glasgow, 1 year
Charles A. Vance, Lexington, 1 year
W. Vinson Pierce, Covington, 2 years
Paul B. Hall, Paintsville, 2 years
Clark Bailey, Harlan, 2 years
George McClure, Danville, 3 years
G. L. Simpson, Greenville, 3 years
J. Vernon Pace, Paducah, 3 years

Committee on Nurse Training

C. C. Howard, Glasgow, Chairman
W. Vinson Pierce, Covington
Charles B. Stacy, Pineville
W. O. Johnson, Louisville
Philip J. Begley, Harlan

Professional Relations Committee

E. W. Jackson, Paducah, Chairman
Guy Aud, Louisville
Charles A. Vance, Lexington
Hugh L. Houston, Murray
Sam A. Overstreet, Louisville

Committee on Training of Ambulance Attendants

C. C. Howard, Glasgow, Chairman
Paul B. Hall, Paintsville

J. Duffy Hancock, Louisville
 Hugh L. Houston, Murray
 Carl Norfleet, Somerset
 Gaithel Simpson, Greenville
 Lillian H. South, Louisville
 Clyde C. Sparks, Ashland
 Charles B. Stacy, Pineville
 Robert R. Starr, Glasgow

Committee for World Medical Association

Clark Bailey, Harlan, Chairman
 (Other members to be appointed at a later date)

ADVISORY COMMITTEES ON MEDICAL CARE

Committee on Cancer

Guy Aud, Louisville, Chairman
 Jesshill Love, Louisville
 John W. Meredith, Scottsville
 J. Farra Van Meter, Lexington
 W. H. Pennington, Lexington
 Richard J. Rust, Newport

Committee on Crippled Children

K. Armand Fischer, Louisville, Chairman
 Charles C. Garr, Lexington
 Charles F. Wood, Louisville
 Hal E. Houston, Murray
 Otto H. Salsbery, Covington

Committee on General Practice

J. Auldin Bishop, Jeffersontown, Chairman
 Travis Pugh, Bowling Green
 John W. Somerville, Maysville
 William M. Brown, Corbin

Committee on Industrial Medicine and Surgery

Gradie R. Rowntree, Louisville, Chairman
 R. W. Robertson, Paducah
 Clyde C. Sparks, Ashland
 Richard J. Rust, Newport
 Ira N. Kerns, Louisville
 Walter L. Cawood, Harlan

Committee on Mental Hygiene and Mental Institutions

Spafford Ackerly, Louisville, Chairman
 Frank M. Gaines, Louisville
 George H. Wilson, Lexington
 Billy K. Keller, Louisville
 John P. Bell, Louisville

Committee on Obstetrics

Coleman J. McDevitt, Murray, Chairman
 Rudy F. Vogt, Louisville
 Stanley S. Parks, Lexington
 Charles L. Cawood, Middlesboro
 Joseph T. Molony, Covington

Committee on Pediatrics

W. W. Nicholson, Louisville, Chairman
 Murvel C. Blair, Frankfort
 Robert L. Biltz, Newport

Lon C. Hall, Paintsville
 Daniel B. McIlvoy, Jr., Bowling Green

Committee on Physical Therapy

McDaniel Ewing, Louisville, Chairman
 Edward B. Mersch, Covington
 Mathew D. Garred, Ashland
 Owen B. Murphy, Jr., Lexington
 Robert W. Hahs, Murray
 William K. Massie, Jr., Lexington

Committee on Rural Health

Walter L. O'Nan, Henderson, Chairman
 Thomas H. Milton, Owensboro
 Donald W. Anderson, Madisonville
 Ruel T. Routt, Sonora
 J. Auldin Bishop, Jeffersontown
 D. G. Miller, Jr., Morgantown
 Harry K. Dillard, Warsaw
 George H. Riley, Erlanger
 John W. Somerville, Maysville
 Ben F. Roach, Midway
 Donald L. Graves, Frenchburg
 Garnett J. Sweeney, Liberty
 Grady Stewart, Olive Hill

Committee on Syphilis Control

Oscar E. Bloch, Jr., Louisville, Chairman
 C. C. Barrett, Lexington
 William F. Lamb, Louisville

Committee on Tuberculosis

T. Ashby Woodson, Louisville, Chairman
 C. C. Howard, Glasgow
 E. R. Gernert, Louisville
 E. J. Murray, Lexington
 L. O. Toomey, Bowling Green
 P. M. Crawford, Louisville

OTHER ADVISORY COMMITTEES

Advisory Committee on United Mine Workers Health and Welfare Fund

Carl H. Fortune, Lexington, Chairman
 C. D. Snyder, Hazard
 Robert S. Howard, Harlan
 Adam G. Osborne, Pikeville
 Charles R. Yancey, Hopkinsville
 George F. Brockman, Greenville

Advisory Committee to Woman's Auxiliary

E. Lee Heflin, Louisville, Chairman
 J. B. Lukins, Louisville
 Hugh L. Houston, Murray

OTHER CONVENTION COMMITTEES

Committee on Scientific Exhibits

Everett L. Pirkey, Louisville, Chairman
 D. Woolfolk Barrow, Lexington
 Harold Gordon, Louisville
 Charles F. Wood, Louisville

Jesshill Love, Louisville
Charles B. Wathen, Owensboro

Committee on Technical Exhibits

Carlisle R. Petty, Louisville, Chairman
Edgar S. Weaver, Carrollton
James E. Hix, Owensboro
Clyde H. Foshee, Louisville
Arthur T. Hurst, Louisville

Psychiatric Bulletin Distributed By Health Department

Most physicians in general practice in Kentucky have received The Psychiatric Bulletin during the past year through courtesy of the Division of Mental Health of the State Department of Health, Arthur R. Kasey, M. D., Louisville, Division Director, said.

The publication is comparable in content and format to The Cancer Bulletin which has wide circulation among physicians in Kentucky. Both are published by the University of Texas.

Purpose of distributing the sample copies of The Psychiatric Bulletin was to stimulate interest among general practitioners in "a publication which furnishes up-to-date and valuable psychiatric information in readable form," Dr. Kasey said.

Published four times annually, the magazine can be purchased for two dollars a year if subscribed for in bulk, with the Division of Mental Health sharing the cost. For further information, contact the Division of Mental Health, Kentucky State Department of Health, 620 South Third Street, Louisville.

Gets Executive Council Post

Charles McGaff, University of Louisville Medical School Junior, who represented the U. of L. Chapter at the Student A.M.A. House of Delegates meeting in Chicago, December 27 and 28, was named to the Executive Council of the Student A.M.A. composed of five members and the officers of the Junior A.M.A. The Council will be the governing body between meetings of the House of Delegates.

AMA Announces Public Relations Aid For Physicians

An attractive new office plaque for prominent display on an office desk or wall has been designed by the A.M.A. to help practicing physicians in their nationwide public relations effort.

For picture of plaque see page XXVI.

Addressed "To All My Patients," the card says "I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient."

Decals indicating the physician's affiliation with a particular state or county medical society may be affixed to the plaque. Physicians may order the card by sending \$1 to the A.M.A. Order Department, 535 North Dearborn Street, Chicago 10.

Publication of Volume Delayed

Publication of the Centennial Volume has been delayed for several months as a result of unforeseen difficulties, Sam A. Overstreet, M. D., Louisville, Chairman of the Centennial Committee, stated.

The volume, edited by Emmet F. Horine, M. D., Brooks, will include all scientific papers together with pictures and biographical sketches of the Centennial essayists, a brief historical sketch of the first 100 years of the Association's activities, an article on McDowell, pictures of the 100 past presidents and other features.

Ten Ways to Kill An Association

(from the News Letter, Massachusetts Medical Society)

1. Don't come to the meetings.
2. If you do, come late.
3. If the weather doesn't suit you, don't think of coming.
4. If you do not attend a meeting, find fault with the officers and members.
5. Never accept an office, as it is easier to criticize than do things.
6. Nevertheless, get annoyed if you are not appointed to a committee.
7. If asked by the Chairman to give your opinion regarding some important matter, tell him you have nothing to say. After the meeting tell everyone how things should have been done.
8. Do nothing more than is absolutely necessary. When other members roll up their sleeves and unselfishly use their ability to help things along, howl that the Association is run by a "clique."
9. Hold back your dues as long as possible—better still don't pay at all.

10. Don't bother about getting new members, but if you do, be sure they are grouches like yourself.

(Age Publications Ltd., Toronto)

Appointed To Reference Committee

Bruce Underwood, M. D., Louisville, one of K.S.M.A.'s Delegates to the American Medical Association Los Angeles meeting, December 4-7, was appointed by the A.M.A. Speaker of the House of Delegates, F. F. Borzell, M. D., Philadelphia, to the important Reference Committee on Medical Education and Hospitals.

To this committee was handed the thorny problem involving the hospital-physician relationship, which was considered by the now famous Hess Report.

Pertinent Paragraphs

In cooperation with the observance of Popular Mechanics' 50th anniversary, the U. S. Junior Chamber of Commerce has adopted a project designed to place a wooden lung respirator for the emergency treatment of polio victims in every community in the U. S. This activity stems from an incident which occurred in Illinois, 2 years ago, when an 8-year-old boy, stricken with polio, was saved by the use of a "wooden lung" until the conventional iron one could be made available. Specifications, drawings, and construction details were printed in the January issue of Popular Mechanics.

The 1951 Heart Fund Campaign, conducted throughout February by the American Heart Association and its affiliates, will help support the greatest effort ever made to find the answers to the unsolved problems of heart disease. Seventy-five per cent of the funds raised will be retained locally by the affiliated Heart Association for research, where facilities are available, and for community programs. The remaining 25 per cent will go to the American Heart Association for national program activities.

The Division of Training of the Cancer Cytology Center of Dade County Cancer Institute, an affiliate of the Medical Research Foundation of Dade County in Miami, Florida, announces its second 1-week seminar for physicians to be held at the Institute, April 21st-25th, immediately preceding the annual convention of the

Florida Medical Association. More than 20 outstanding local and visiting physicians and scientists will compose the faculty. Inquiries should be directed to Dade County Cancer Institute, 1155 N. W. 14th St., Miami, Florida.

A film for physicians entitled "The Diagnosis of Acute Poliomyelitis" is available for loan to the members of the medical profession. This 16 mm. sound film runs 37 minutes, was produced by the National Foundation for Infantile Paralysis, Inc., and can be secured by contacting Mr. Frank Shook, Audio-Visual Department, Louisville General Hospital, 323 East Chestnut Street, Louisville, Kentucky.

The A.M.A. has had requests from bar associations for the "Simplified Blueprint of Campaign" against compulsory health insurance, as lawyers prepare to fight any proposal that might lead to the socialization of law. The California Bar has taken steps to establish a lawyer reference service for the purpose of aiding clients who do not know how to find a reputable attorney, a project which is similar to that undertaken by county medical societies' emergency call services.

Opposition to socialized medicine is growing more widespread, the Christian Science Monitor said recently. The reason for this, the paper said editorially, is that its recent costly experience in Great Britain and parts of Canada have figured so notably in the news that the American public is at last becoming informed. Credit for the diminishing enthusiasm in Congress for health insurance can be given in part to the number of national organizations which have recorded their disapproval. The paper warns, however, that sustained opposition is still clearly necessary.

Sessions of the Association of State and Territorial Health Officers, meeting with the U. S. Surgeon General and Children's Bureau officials, were dominated by the impact of national defense on programs and budget, the AMA Washington Office reports. A budget Bureau official made it clear that there was little prospect for increased funds, unless the expenditures could be tied directly to the defense effort. The conference called on Federal Civil Defense Administration to make immediately available to states specified items for training, and to expedite dissemination of instruments for radiological, biological and chemical warfare defense.

County Society Reports

MADISON

The Madison County Medical Society held its first regular monthly meeting for the year, 1952, at Berea College Hospital, Berea, Kentucky, on January 10, 1952, at 7:30 P. M.

Dr. Paul Harrison, Berea College Hospital Surgeon, gave an interesting report on "The Use of Penicillin in the Treatment of Appendicitis." In his paper, he pointed out that very early cases of appendicitis responded well to penicillin therapy in three to four days as cured and to date no recurrent attacks, except two cases had repeated attacks and these were treated surgically by removal of the appendix.

Dr. Harrison had fourteen cases that had complications such as local peritonitis and rupture due primarily to improper handling before they were admitted to hospital, delay in diagnosis, unnecessary cathartics, etc.

Penicillin schedule used by Crile was instituted in all cases of appendicitis, the later cases were changed and now Terramycin is used with better results by Berea College Hospital.

This paper was discussed by all present.

Dr. J. W. Armstrong has been studying Histoplasma infection of the lungs and Dr. Armstrong previously presented this paper to the Medical Society in 1946 and has added more to his previous work. There have been a few cases diagnosed as tuberculosis which can be readily differentiated by proper skin test. These skin tests should be used together with the Mantoux test so that this error can be eliminated. Dr. J. W. Armstrong's paper will be submitted for publication at a later date.

The Madison County Medical Society has arranged to have the Telephone Medical Program piped into the First Presbyterian Church in Richmond, Kentucky, on dates scheduled by the State Medical Association.

Dr. J. Bates Henderson, President, called the meeting to order. The meeting adjourned at 9:00 P. M.

Max E. Blue, M. D., Secretary

MUHLENBERG

The Muhlenberg County Medical Society met on January 4, 1952. Members present: Drs. Walton, Woodson, Simpson, Davis, Brockman, Bechtel, Claude Wilson and F. Wilson.

1. The meeting was called to order by the President, Dr. F. Wilson.

2. Minutes of the last meeting were read and approved.

3. Unfinished Business—The secretary reported the receipt of a communication from the State Health Department as a purported answer to specific inquiries regarding infectious hepatitis. Dr. Bechtel, who made an abstract of the report, stated specific questions asked were not answered. Considerable discussion followed and it was decided to drop the matter, as the information reported would not be forthcoming.

4. Communications—A letter from the Fayette County Medical Society requested support for resolution "to quarantine communicable cases of tuberculosis; and in order to make enforcement possible, to provide adequate penalties for violations." On motion of Dr. Davis, seconded by Dr. Simpson, it was moved "that the Muhlenberg County Medical Society favors the quarantine of cases of contagious tuberculosis, and favors statutory enactment for this if ever adequate facility for effective quarantine can be provided."

5. The secretary submitted information from the treasury, and the society approved the tentative schedule of dues. The secretary was authorized to allow Dr. C. G. Crowder to specify whether or not he wishes to remain as an active or honorary member of this society.

6. Election of Officers: The following officers were elected: President—Dr. C. Wilson; Vice-President—Dr. R. E. Davis; Secretary—Dr. G. F. Brockman; Delegate—Dr. G. H. Rodman; Alternate Delegate—Dr. F. Wilson; and Censor—Dr. G. L. Simpson.

7. On motion, the meeting was adjourned.

G. F. Brockman, M. D., Secretary

SCOTT

The Scott County Medical Society held its regular monthly meeting on Thursday, January 3, 1952, at the John Graves Ford Memorial Hospital with the following members in attendance: Drs. D. E. Clark, Jr., P. H. Crutchfield, H. G. Wells, A. F. Smith, F. W. Wilt, E. C. Barlow, H. V. Johnson and Mr. Joe Kelly, administrator of the Hospital.

The Secretary read a letter from Dr. John S. Sprague, Secretary of the Fayette County Medical Society, urging us to use our influence toward the passage of a bill to quarantine com-



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for use when oral administration is difficult or impractical
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Banthine—a true anticholinergic drug with an adequate range of safety—is now made available to the medical profession in parenteral form, for use intravenously or intramuscularly in those conditions characterized by nausea and vomiting, when oral medication cannot be retained and when a prompt action is desirable.

Through its anticholinergic effects, Banthine inhibits excess vagal stimulation and controls hypermotility.

In Peptic Ulcer—the value of the oral form of Banthine is now well established. However, edema in the ulcer area may indicate parenteral Banthine until the healing processes have reduced the edema.

In Pancreatitis—it has been found that parenteral Banthine relieves pain, effects a fall in blood amylase and produces a general improvement in the patient's condition.

In Visceral Spasm—it inhibits motility of the gastrointestinal and urinary tracts.

Parenteral BANTHINE is supplied in serum-type ampuls containing 50 mg. of Banthine powder. Adult dosage is generally the same as with Banthine tablets.



RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

municable tuberculosis cases and providing a penalty for violation. Motion was made and seconded that we endorse this measure and the Secretary be instructed to write our Senator and Representative to that effect. Carried.

Dr. Clark appointed the following committees: Legislative—Dr. Johnson and Dr. Barlow; Public Relations—Dr. Allphin and Dr. Wilt; Rural Health—Dr. Smith and Dr. Clark; and Emergency Medical Service—Dr. Wells and Dr. Heath.

Mr. Kelley, our Hospital Manager, discussed some of our local problems.

There being no further business, the meeting adjourned.

H. V. Johnson, M. D., Secretary

SHELBY-OLDHAM

The Shelby-Oldham Medical Society was entertained by B. B. Sleadd, M. D., with dinner at the Methodist Church in Middletown on December 20th.

The following members and guest were present: Drs. M. F. Beard, H. H. Richeson, L. M. Simon, A. C. Weakley, H. B. Mack, B. F. Shields, A. D. Doak, George Ray, B. B. Sleadd, C. C. Risk and E. H. Sanneman, Jr.

This being the annual meeting the following officers were elected:

H. T. Alexander, M. D., Crestwood, President

J. T. Walsh, M. D., LaGrange, Vice-President

C. C. Risk, Shelbyville, Secretary and Treasurer

M. F. Beard, M. D., of Louisville, gave a talk on the uses of Cortisone.

The next meeting will be on January 24th, 1952.

C. C. Risk, D. D. S., Secretary

UNION

A special meeting of the Union County Medico-Dental Society was held December 18, 1951, at 7:30 P. M.

The meeting was called to order by the president, William Humphrey, M. D.

The secretary presented a communication from the K.S.M.A. on postgraduate instruction by live broadcast, and also stated Mr.

Jones, field secretary, was in conference with him on this matter a few days ago.

By unanimous vote it was decided to participate in this program, given by the K.S.M.A. Medical Education Committee, through the facilities of the Southern Bell Telephone Company, direct from the General Hospital in Louisville, under arrangements made with the University of Louisville School of Medicine.

The local society understands they are to make the local arrangements for a wire and loud speaker to the reception hall.

The payment of \$10.00 for these instructions was passed.

On recommendation from the secretary, it was decided to have a monthly meeting instead of quarterly. It was felt that a program of interest each month would create more interest and bring out more members.

The secretary and president together will plan and secure a program each month.

January 15, 1952, will start the regular monthly schedule with a speaker. The third Tuesday of each month the society will meet at 7:30 P. M. except on the three dates the broadcasts come on. These will be according to the schedule set.

Members present were William Humphrey, M. D., G. B. Carr, M. D., J. W. Conway, M. D., C. B. Graves, M. D., H. B. Stewart, M. D., George Welker, Jr., M. D., and W. H. Pueryear, D. D. S.

There being no further business, the meeting was adjourned.

A. W. Andreasen, M. D., Secretary

WARREN-EDMONSON-BUTLER

The Warren-Edmonson-Butler County Medical Society met the 11th of December, 1951, at the Helm Hotel in Bowling Green for its monthly dinner meeting.

The society voted to participate in the post-graduate broadcast program.

The following officers for 1952 were elected:

Travis B. Pugh, M. D., President

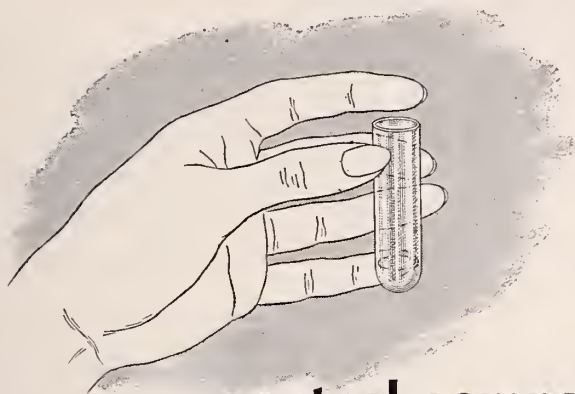
Henry S. Harris, M. D., Vice-President

Frank H. Moore, M. D., Secretary and Treasurer

Carlos Fish, M. D., of Louisville, gave a most interesting discussion of Hypoglycemia.

There were twenty members present.

Frank H. Moore, M. D., Secretary



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Sprague, R. G.: Cortisone and ACTH, Am. J. Med. 10:567, 1951.

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News Items

Harry S. Andrews, M. D., Brown Building, Louisville, has announced his association with **Kenneth P. Crawford, M. D.**, who will limit his practice to pediatrics. Dr. Crawford is a graduate of the University of Louisville School of Medicine in 1946. He interned at St. Joseph Infirmary, Louisville, and then served two years in the Army before taking a residency there.

L. F. Heath, M. D., Georgetown's oldest physician, both in years and service, has delivered more than 2,200 babies during his 47 years in practice, according to a story about him in the Lexington Herald, December 20. Dr. Heath, who recently celebrated his 80th birthday, was born in Owen County, and received his medical degree from Hospital College of Medicine, Louisville. He began his practice in 1904 at Minorsville, moving to Georgetown in 1914.

John B. McHugh, M. D., formerly chief of professional services at the VA Hospital in Outwood, Kentucky, will become manager of the 498-bed VA hospital at Kansas City, Missouri, which is still under construction. VA has announced. Dr. McHugh, a member of Christian County Medical Society while in Kentucky, has been manager of the VA Hospital at Minot, North Dakota, since 1950.

James R. Freedman, M. D., has become associated with the Graves-Gilbert Clinic at Bowling Green. Dr. Freedman will take the place of Leonard Lamb, M. D., who has moved to South Bend, Indiana. Dr. Freedman has just completed his training at St. Joseph Infirmary in Louisville.

Alice Pickett, M. D., retired the first of the year from her 38-year practice as an obstetrician in Louisville. A native of Shelby County, Dr. Pickett obtained her medical degree from Women's Medical College, Philadelphia, Pennsylvania, in 1909, and located in Louisville 4 years later. She took time out during World War I to go overseas to serve as a civilian doctor with the Red Cross. Upon her return she joined the staff of the University of Louisville Medical School, from which she resigned as head of the department of obstetrics in 1946. Now professor emeritus of obstetrics, Dr. Pickett's popularity has become legendary, both with her students, who continue to write her, and the many women of Louisville, whose children she has delivered.

In Memoriam

ANDREW JACKSON HILLMAN, M. D.

Ashland

1870 - 1952

Dr. Andrew Jackson Hillman died December 5th at Ashland. He was born in Elliott County, July 7, 1870. He taught in the Elliott County public schools and later attended the Cincinnati University. He was graduated from the Louisville School of Medicine in 1895 and practiced his profession in Elliott, Carter, Lawrence and Fleming counties before moving to Ashland in 1916. Ill health forced him to retire in 1930.

He was a member of the Kentucky Medical Society, a former president of the Boyd County Medical Society and was a member of the Boyd County Board of Education. He was active in many civic affairs.

A. L. BLAIR, M. D.

Winchester

1863 - 1952

Dr. A. L. Blair, 89, a retired physician who practiced at Morehead and Ashland, died January 6 at Clark County Hospital. He was born in Portsmouth, Ohio, and later moved to Winchester.

He was a member of the Kentucky and American Medical Associations and the Masonic Lodge.

ROBERT MAY PHELPS, M. D.

Richmond

1875 - 1951

Robert May Phelps, prominent physician, died December 23, 1951 in Richmond where he had practiced medicine for 38 years.

A native of Madison County, Dr. Phelps attended Central University at Richmond and was graduated from Chicago Medical School in 1897. He practiced in Versailles and Paducah before finally locating in Richmond.

Dr. Phelps served as medical officer in World War I and for 19 years was commander of a hospital company of the Kentucky National Guards.

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The Clinical Significance of Potassium Metabolism

GEORGE W. PEDIGO, JR., M. D.

Louisville

Disturbances in potassium metabolism have become in recent years a problem of considerable clinical significance. A better understanding of water and electrolyte solutions and their administration is enabling the physician to save many patients who previously would have died. Optimal parenteral electrolyte and fluid therapy can be achieved only by judicious provisions of sodium chloride, water, glucose and potassium.

Potassium¹ is the chief cation of the intracellular fluid, whereas sodium is the chief cation of extracellular fluid. About $\frac{3}{4}$ ths of the body potassium is found in the muscles. The red blood cell content of potassium is high with a concentration of 420 mgm. per 100 cc. in contrast to a blood serum potassium concentration of only 16-22 mgm. per 100 cc. or 4.1 to 5.6 milliequivalents.

Potassium Content of Foods and Intestinal Juices

Under conditions of normal gastrointestinal function potassium is practically completely absorbed from the gastrointestinal tract. Less than 10% of the potassium ingested is eliminated normally in the feces. The kidneys excrete 90% of the ingested potassium. Normally the total excretion of potassium parallels the intake. The average daily diet contains about 3.5 to 5 grams or 90 to 125 milliequivalents of potassium². Usually about one-third of the dietary potassium is derived from milk, one-third from vegetables and one-third from meat³. Some

of the foods rich in potassium are as follows: (expressed in mg. per 100 grams)

Molasses	1350	Sweet Potatoes	400
Raisins	820	Bananas	390
Olives	800	Beets and turnips	350
Peanuts	650	Beef and lettuce	320
Parsnips	530	Carrots and fish	310
Wheat	470	Coconuts and figs	300
Oatmeal	400	Orange juice	180

Meat broth is high in its concentration of potassium with one well known meat extract preparation containing in four tablespoonsful the equivalent of 5 to 6 grams of potassium chloride.

The potassium³ content of saliva is 100 mg. per 100 cc. and with a daily production of 1,000 to 1,500 cc. of saliva it can readily be seen that unless the saliva is re-absorbed by the gastrointestinal tract that an appreciable amount of potassium could be lost each day in this way.

The potassium⁴ content of gastric juice is about 30 mg. per 100 cc. normally. It has been shown that under certain conditions the gastric concentration of potassium may be several fold greater than the plasma blood level. If there is normally about 2,500 cc. of gastric juice secreted daily, it is again apparent that considerable potassium could be lost if these juices were not re-absorbed by the intestinal tract.

Factors Influencing Intra and Extracellular Concentration of Potassium

No other cation can easily replace potassium in the intra-cellular fluid or tissue cell without interfering to a certain extent with the functional activity of the

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cell¹. Any considerable replacement of sodium by potassium in the extracellular fluid is accompanied by serious disturbance and is eventually fatal. Potassium is prevented from diffusing out of the cells by a membrane or some other restraining factors present in the cellular and extra-cellular media. Potassium is not fixed in its predominantly intracellular position, but can shift about in the body according to the demands of shifting membrane equilibria. This equilibrium is disturbed by acid-base imbalances which allow potassium to pass out of the cell. The co-existence of intracellular potassium deficiency and metabolic alkalosis has been demonstrated clinically and experimentally by Darrow⁵⁻⁶ and his co-workers. Hypochloremic alkalosis is frequently found after excessive loss of gastric juice and intracellular potassium loss has been recognized under these conditions. A definite correlation exists between the degree of alkalosis and the lowering of muscle potassium content. Sodium is frequently retained and the excess sodium migrates into the cell to replace the lost potassium.

Potassium² moves into tissue cells when there is a positive nitrogen balance and it moves out of the cells when there is a negative nitrogen balance.

Potassium² passes from tissue cells into extracellular fluids when excessive quantities of water and sodium are lost from the body as in hemorrhage, shock, adrenal insufficiency, intestinal obstruction and various gastro-intestinal fistulae. In circulatory insufficiency or shock, there may be a normal or higher normal serum potassium level in the presence of marked depletion of intracellular potassium.

Potassium² passes into the blood plasma from the tissue cells during increased muscular activity and during periods of increased metabolism. Potassium increases in the tissue cells, at the expense of the blood plasma level, during anesthesia and rest. Potassium is intimately related to carbohydrate metabolism and is stored in the liver during glycogenesis. Potassium passes with glucose from the liver to the muscle cells and from the muscle to the liver with lactic acid.

The extra-cellular concentration of potassium⁷ falls after insulin administration with potassium being driven into the tissue cells.

Adrenalin will cause a sharp rise in

serum potassium² concentration. This phenomenon appears to be dependent upon mobilization of potassium from the liver.

Testosterone⁸ causes a fall in serum potassium level driving potassium intracellularly.

Desoxycorticosterone⁹, ACTH and Cortisone¹⁰ cause increased excretion of potassium.

If an excess of sodium chloride and water is given parenterally, potassium¹¹ excretion is increased. Potassium¹² is driven intra-cellularly by parenteral glucose with less potassium excreted in the urine than would be found if an equal amount of intravenous saline had been given.

Adults on normal potassium intake who have a sudden deprivation of the potassium intake will continue to excrete potassium in the urine in excess of that expected from the nitrogen balance and a negative potassium balance may result. This continued potassium loss in the kidney with little, if any, intake of potassium allows the kidneys¹³ to play a major role in the development of serious intra-cellular potassium deficits.

Increased excretion of potassium¹⁴ in the urine may occur because of altered tubular function with impaired re-absorption. Altered tubular re-absorption may be caused by changes in pH, anoxia, shock, upper or lower nephron nephritis, and occasionally glomerulonephritis. ACTH, Cortisone and desoxycorticosterone may also alter the tubular re-absorption of potassium, increasing the elimination of potassium.

Mechanisms in the Body

The mechanisms in the body which seem to regulate potassium¹ metabolism seem intimately related to the adrenal cortex. There is considerable evidence that the fundamental action of one of the adreno-cortical hormones is to regulate the metabolism of potassium in the body. It has been suggested that the adrenal cortical hormone affects the permeability of the cell in regard to potassium. It has been found that people with adrenal insufficiency, as in Addison's disease, exhibit a diminished tolerance to ingested potassium. Normal persons fed 10 mgm. of potassium per pound of body weight get no significant rise in the serum level of potassium. Potassium, in similar amounts,

given to individuals with adrenal insufficiency exhibit a sharp increase in serum potassium concentration within 30 minutes after ingestion of the potassium with a subsequent fall of serum potassium to within normal limits in 1½ hours. Decreased concentration of potassium in the blood serum has been observed in increased adrenal cortical function, exemplified by Cushing's disease.

An increase in serum potassium concentration is one of the most constant metabolic features of Addison's disease. The increase in serum potassium is accompanied by a decrease in potassium elimination in the urine and an increase in potassium content of the erythrocyte and muscle cells.

Surgical trauma¹⁵ or tissue injury from accidents, myocardial infarcts, acute infections, radiation, nitrogen mustard, etc. may cause an increased production of ACTH by the pituitary gland with stimulation of the adrenals in an alarm reaction to produce Cortisone with a resulting potassium deficiency.

While the gross mechanisms of potassium changes in the body are known, many of the fundamental problems, such as the mechanisms by which potassium enters the cell against a high diffusion gradient, the factors governing tubular reabsorption and the forces that prevent cellular potassium from being supplied to correct serious, but small, extra-cellular deficits are unsolved.

Function of Potassium in the Body

It appears that a specific intra-cellular content of potassium¹⁶ is essential for the proper functioning of certain enzymatic processes of the cell, notably those concerned with carbohydrate metabolism. The disposition of glycogen in the liver could not take place unless accompanied by a certain amount of potassium and water.

Potassium¹⁶ plays a vital role in maintaining iso-osmotic equilibrium between the extra and intra-cellular fluids. Potassium helps to preserve the normal pH of the body fluids by its potentialities as a buffer.

Potassium is essential for normal muscle function. The establishment of a proper level of muscle irritability depends to a great extent on potassium. Potassium is intimately connected with the contractile process. Weakness, loss of muscle tone

and muscle paralysis may result from a low potassium cellular level.

Potassium¹⁷ is essential for normal nerve function. It is particularly concerned in the neuromuscular transmission of the impulse. It also acts in initiating the excitation process. In low concentration, potassium is excitatory and in high concentration, it is inhibitory, these effects being particularly important in relation to nerve synapses or myoneural junctions.

Potassium has a pressor effect similar to epinephrine.

Potassium is essential for normal cardiac function. Low potassium levels may produce cardiac dilatation and the development of systolic murmurs and arrhythmia with profound EKG changes of a type associated with severe grades of myocardial abnormalities. Focal myocardial necrosis¹⁸, cellular infiltration and fibrosis, focal endocarditis have been described at autopsy in patients with potassium deficiency.

The musculature of the gastrointestinal tract depends on potassium for normal function with a low potassium cellular level producing decreased motility and inhibitions, obstructions adynamic ileus.

Electrocardiographic Changes Associated with Abnormal Potassium Metabolism

The electrocardiogram¹⁵ may in certain cases be a better index of tissue potassium deficit than the serum potassium level. This would fit observations¹³ that there may be considerable tissue loss of potassium without a lowered level of extra-cellular potassium. Frequently when parenteral potassium is given to an individual with an intra-cellular potassium deficiency, there is a delayed return of the serum potassium level to normal in spite of large doses of potassium. This is apparently an indication of marked cellular depletion of potassium which must be corrected before the serum level will return to normal.

The characteristic electrocardiographic findings associated with hyperpotassemia are quite well established¹⁷. A characteristic tall narrow T wave is seen which is frequently accompanied by a widening of the QRS complex. Ventricular arrhythmias have also been reported. These changes are reversible if the hyperpotassemia can be corrected.

In 1937 Billet and Dyer¹⁹ reported characteristic electrocardiographic changes in patients emerging from diabetic

acidosis. They reported a lengthening of the QT interval, depression of the S-T segments and in some instances, lowering or inversion of the T waves. The relation of these changes to hypopotassemia was not established originally. Since this time the above changes have been verified with the additional findings of ectopic rhythms and a prominent U wave in many cases¹⁵. These findings have been found in association with a low serum potassium level and have been corrected by the administration of potassium. It is thought therefore that the observed and reported electrocardiographic changes are probably due to a myocardial potassium deficit.

Summary

A review of the physiology of potassium metabolism has been presented. Emphasis has been placed on the factors which influence the intra-cellular and extra-cellular concentration of potassium, and on the functions of potassium in the body. A brief review of the electrocardiographic changes produced by both hypopotassemia and hyperpotassemia is also presented.

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Clinical Use of Potassium in Common Disorders

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Louisville

It is the purpose of this paper to correlate the physiological concepts of potassium metabolism given by the preceding speaker with the clinical use of potassium in common disorders.

Hyperpotassemia

In hyperkalemia the patient complains first of vague weakness which may become manifest by obvious loss of muscular strength. This in turn progresses to complete flaccid paralysis of the extremities, accompanied by loss of tendon reflexes, and, later to difficulty in phonation and

respiration, secondary to weakness of the musculature involved in these processes. Preceding this clinical picture and progressing with it are marked and characteristic electrocardiographic changes, the importance of which is evident when it is realized that the terminal event is cardiac asystole, often preceded by ventricular fibrillation or tachycardia. Frequently, even in severe cases, the patient is alert and apprehensive, even when muscular paralysis is apparent. Maintenance of consciousness and adequate levels of blood pressure until cardiac arrest is not infrequent. Cardiac irregularities, or bradycardia, may accompany the clinical pic-

ture. The mental status is to some extent determined by the degree of azotemia and its concomitant drowsiness. It is not uncommon, however, in states of severe electrolyte imbalance, to see marked potassium intoxication in face of minimal degrees of nitrogen retention. Addisonian crisis is an example.

Etiological Factors

A number of factors partake in the production of potassium intoxication, and the presence of one or more of these should alert the clinician to the possibility. Of these, perhaps the most important is suppression of the urine volume. Hyperkalemia, severe enough to be associated with the clinical syndrome, is a rarity in the absence of oliguria (less than 500 cc.'s per 24 hours). However, potassium intoxication may be observed in patients without oliguria or anuria in the presence of high potassium intake or of sodium depletion, especially when both occur simultaneously or when the rate of change in either direction is rapid. In patients with marked oliguria the concentration of potassium in the urine often exceeds 60 mEq/L. In a urine volume of 100 to 200 cc.'s per day this is inadequate to accommodate the demands for excretion of potassium supplied to the plasma by ingestion, catabolic processes and shift from the cells. Sudden death in these cases is usually due to cardiac asystole caused by potassium intoxication, therefore, it is important that the recognition and treatment of this serious complication of urinary suppression be a matter of common knowledge.

The inability of the oliguric patient to excrete large quantities of potassium requires that his intake of potassium be negligible. If such a patient be maintained on parenteral fluids alone, this becomes a simple matter. However, the ingestion of food or fluids should be carefully supervised. Orange juice, one of the commonest of fluids administered to a hospitalized patient, contains relatively large amounts of potassium. Another common source of exogenous potassium is the breakdown of red blood cells which occurs with an incompatible transfusion. Such a situation frequently is to blame for the subsequent anuria or oliguria, as well as for releasing potassium which the patient is then unable to excrete. Fever, the post-surgical state with or without oliguria, and any variant of the "alarm re-

action" are examples of increased normal catabolic processes which may increase the possibility of increased levels of extracellular potassium.

There is evidence that the abnormal metabolic status of the oliguric or anuric patient may predispose to transfer of potassium without nitrogen from its intracellular position to the extracellular fluid. Such transfer has been found to occur in patients with renal insufficiency and under conditions of anoxia. The expansion of extracellular volume in itself may lead to transfer of potassium from cells. This expansion may occur as the result of the infusion of large amounts of hypertonic solutions at a rapid rate which may later result in hypotonicity as glucose is metabolized and excess water retained. This, therefore, decreases its long-term therapeutic value in potassium intoxication, although the immediate effect may be dramatic.

Severe degrees of acidosis predispose to potassium intoxication. Correlation has been noted in both diabetic acidosis and artificially induced acidosis between low blood pH and the increased T waves seen in the electrocardiograms of potassium intoxication. It has been noted in nephrotics¹ that while red cell potassium could be increased by the administration of potassium chloride, this was not possible after the production of acidosis by ammonium chloride. Therefore, it may be of value to stop ammonium chloride therapy in congestive heart failure when potassium deficiency is suspected. Biochemical opinion² at present holds that the alkaline reserve is decreased late in pregnancy due to the demands for base by the fetus. In uncomplicated pregnancy, however, there is no problem as to potassium balance as long as the kidneys are not seriously diseased and there is an adequate intake of food. Vomiting (lack of normal free hydrochloric acid) and insufficient carbohydrate intake to spare body protein are factors in producing acidosis in toxemias of pregnancy, therefore, they should not be overlooked. Portal cirrhosis with ascites treated by frequent paracenteses, low salt and low chloride diets may be complicated by hyperkalemia. Respiratory acidosis, because of shallow respirations associated with high CO₂ combining power but low pH, may cause hyperkalemia. It seems probable then that acidosis per se is a factor in production of the potassium effect only as it affects potassium

transfer or the ratio of the intracellular and extracellular ion.

It is usual to find low potassium values in alkalosis, however, if anuria exists and the serum potassium is high there is no clinical or electrocardiographic evidence of intoxication.

Diagnosis of Potassium Intoxication

Diagnosis of hyperkalemia is feasible when early symptoms previously discussed are associated with the etiological factors just mentioned plus positive serum and/or electrocardiographic evidence of hyperpotassemia is present. Although there is a lack of direct correlation between the absolute chemical values and the changes in the electrocardiogram, there is a parallelism between potassium intoxication. Therefore, it is the single most important guide to the progress and therapy of the patient with incipient or actual potassium intoxication. The electrocardiogram, however, is not a substitute for the measurement of the concentration of serum potassium since the electrocardiogram will not reflect high serum potassium values accompanied with normal serum sodium but it still is a more reliable clinical index reflecting the patient's physical reaction to potassium.

Treatment of Potassium Intoxication

It is known that calcium salts combat the toxic effects of potassium upon the heart muscle. Finch, however, showed that calcium was a less effective overall therapy than was the infusion of sodium.

The physiologic antagonism of sodium and potassium is well known, and infusions of hypertonic saline have been suggested in the therapy of hyperkalemia by Finch et al³. It is possible that this may be correlated with the observation that acidosis enhances the possibility of potassium intoxication, both mechanisms stemming from an intracellular movement of the sodium ion. About 300 cc.'s of 3 to 4% sodium chloride or sodium bicarbonate is used to lower the serum potassium level but its clinical and chemical effect is very brief, lasting frequently only 40 to 60 minutes. Hypertonic saline infusions may be of lasting value, if serum sodium depletion is exogenous (rather than moving intracellularly) and has played a role in the production of potassium intoxication.

Decrease in extracellular potassium levels following the administration of glu-

cose and insulin has been recognized for sometime, and hypokalemia is not an infrequent sequel to the treatment of diabetic coma with large doses of insulin. The mechanism by which reduction of potassium occurs is the formation of a monopotassium salt and its deposition with hexosediphosphate during the process of glycogen formation and storage in liver and muscle tissue. Later in the process, the potassium and phosphate are released from combination and made available for excretion. This would account for the immediate improvement in glucose-insulin treatment of potassium intoxication and the later regression of symptoms and signs of hyperkalemia. Intravenous infusion of a solution of fifty grams of glucose and 25 to 30 units of crystalline zinc insulin is used and is the most valuable and the least hazardous of the parenteral forms of therapy⁴. Its effect appears to be of greater duration and most consistently reproducible.

The retention of nitrogen, phosphate, and potassium has been demonstrated to follow the administration of testosterone, especially testosterone propionate. This may be of value in preventing to some extent rapid release of phosphate, nitrogen, and potassium to the extracellular fluid of the anuric patient. Merrill et al⁴ administer to these patients testosterone propionate, in an initial dose of 50 mg. intramuscularly, to be followed by 25 mg. daily for four to five days. The apparent increase in kidney mass and tubular hypertrophy found after the administration of testosterone may have some application to the healing of the renal lesions in the patients with "lower nephron nephrosis."

The adrenal steroids may be of some benefit in the prophylaxis of potassium intoxication, especially with the simultaneous use of glucose and insulin. Nitrogen retention, however, may complicate its use. It would appear that Cortisone or whole extract would probably be the most beneficial adrenal substances to use. Further research on this problem is in progress.

Since saline and hypertonic glucose are used in perfusion of the large bowel, it is not clear how much of the beneficial effect was due to removal of potassium ion and how much was due to the absorption of sodium chloride and glucose. Of the methods available, however, there is no question but dialysis, which permits artificial removal of potassium, the addition

of glucose and sodium, removal of metabolites and simultaneous correction of acidosis, is the most effective and lasting method. The effect of dialysis is complete and is measured in terms of days, as opposed to the infusion of glucose and insulin where the effect is often partial and measured in terms of hours.

Cation exchange resins represent an effective method of removal of potassium. These resins require a certain period for their activity to be felt, since they must pass through the alimentary canal to a point where the potassium will be available to them. They must be given in fairly bulky quantities and their action is not entirely predictable nor quantitative⁵.

Hypokassemia

The signs and symptoms of hypokalemia are very similar to those of hyperkalemia, and have usually been related to the change in the serum potassium level. (Some workers feel that the balance between the extracellular and intracellular components may be the more important factor). Decreased serum potassium concentration affects neuromuscular physiology involving the skeletal muscle, cardiac muscle, and the smooth muscle of the gastrointestinal tract. Weakness due to paralysis of the muscles of the trunk and extremities (rarely the muscles supplied by the cranial nerves) may occur when the serum potassium level falls below 2.05 to 2.56 mEq. per liter (8 to 10 mg. %). Changes in conduction, irritability, and contractility of cardiac muscle occur with levels under 2.56 to 3.07 mEq. per liter (10 to 12 mg. %) and are manifested by typical electrocardiographic changes. Clinically, systolic murmurs and gallop rhythms, cardiac dilatation, and hypotension have been noted. If the potassium deficit is severe cardiac arrest and death may occur. Actual necrosis of cardiac muscle has been produced by potassium depletion. Lowered serum potassium may affect the musculature of the gastrointestinal tract to cause decreased motility and adynamic ileus. Hoffman feels that the most fatigued muscles, which differ with various diseases, will show the most weakness and thereby will show the greatest effect of the low serum potassium.

Etiological Factors

A number of factors partake in the production of potassium deficiency, and the

presence of one or more of these should also alert the clinician to the possibility. Of these, perhaps the most important is a decreased intake of potassium. Martin et al⁶ in their series of 150 cases found that 87% had gastrointestinal disorders which were complicated by poor or no food intake, and had been treated by nasogastric suction and potassium free parenteral fluids. These gastrointestinal diseases included intestinal obstruction, cholecystic disease, peritonitis, pyloric obstruction, pancreatitis, and gastrointestinal malignancies. Other conditions which may be complicated with hypokalemia because of poor food consumption are: Severe malnutrition associated with a negative nitrogen balance, toxemias of pregnancy with good kidney output and low carbohydrate intake usually accompanied with acidosis, rest, anesthesia, post operative anorexia with gastrointestinal sequelae, bulbar poliomyelitis⁷, and pyloric stenosis, congenital⁸.

Excessive losses of potassium from the gastrointestinal tract or urine are other important factors in hypokalemia, such as diarrhea, especially in infants, ileostomy, lower nephron nephrosis—recovery phase, chronic nephritis, sprue, desoxycorticosterone acetate therapy in Addison's disease, Cortisone and ACTH therapy⁹, Cushing's syndrome because of action of anteriorpituitary adrenotrophic hormone, cation exchange resins, and parenteral glucose therapy which stimulates potassium diuresis by producing a transient depletion of salt. Potassium serum levels are increased together with lactic acid when metabolism is increased as in muscular exercise, hemorrhage, asphyxia, fever, hyperthyroidism, etc. But hypokalemia may occur in these conditions if good renal function is present¹⁰.

The shift of potassium into the cells occurs in diabetic coma treated with insulin, familial periodic paralysis, and parenteral saline and glucose therapy.

Treatment of Potassium Deficiency

For prophylaxis of potassium deficits a 0.1 to 0.2 per cent solution of potassium chloride (1 to 2 Gm of potassium chloride per liter of any type of intravenous fluids required) given no faster than 1 Gm per hour. For therapy of serious potassium deficits 0.3 to 1.0 per cent solution (3 to 10 Gm of potassium chloride per liter of any type of intravenous required) administered slowly and followed

by frequent serum potassium determinations or electrocardiograms. 0.1 to 0.2 per cent potassium solutions may be given by hypodermoclysis, also.

It is felt by Martin et al⁶ that 3 to 6 Gm of potassium chloride daily is an average prophylactic amount for patients requiring several days of parenteral fluids therapy. It is better to err on the side of too much rather than too little potassium for prophylaxis, since excess potassium is readily excreted by the kidney unless renal function is seriously impaired.

It has been found that 3 to 9 Gm of potassium chloride is required to correct acute deficits as contrasted with 33 to 40 Gm for chronic deficits associated with serious cellular depletion. For the correction of acute deficits 3 Gm of potassium chloride is given parenterally in 24 hours. This is in addition to the prophylactic maintenance dose of 3 to 6 Gm. For serious chronic deficits 19 to 20 Gm of potassium chloride is given intravenously in 24 hours or 10 Gm intravenously and 10 Gm orally, if the oral route can be used.

As soon as patients are able to eat, potassium deficits usually cease to be a problem since an adequate amount of potassium can be obtained from the average diet for maintenance and gradual correction of deficits.

In the cases of diabetic coma undergoing treatment, 12 to 16 Gm of potassium chloride should be given during the first 24 hours of intensive insulin treatment, 2-4 Gm of potassium chloride intravenously (0.1 to 0.2% concentration) and 10 to 12 Gm orally. Therapy should be started as soon as dehydration is partially corrected and renal function is found to be adequate. This is important in that in any near shock condition vital functions should be restored first, such as blood volume, oxygen carrying power, blood pressure, renal circulation and normal pH. The use of Ringer's solution instead of isotonic sodium chloride solution for the initial injections will at least tend to prevent the dilution of extracellular potassium concentration¹¹.

For infants the dosage schedule recommended by Darrow (0.20 Gm of potassium chloride per kilogram of body weight per 24 hours) may be used.

There are two conditions in which the administration of potassium might be dangerous, namely, in the presence of renal damage, and in the presence of severe

myocardial damage¹². While it is felt that renal azotemia is an absolute contraindication to potassium administration, it is not so certain that the same is true in patients who have pre-renal azotemia associated with a low serum potassium as is not infrequently observed in dehydration states. In such patients, the administration of potassium cautiously may be of help. It has recently been shown that toxic levels of serum potassium is modified by the cardiac state. In dogs with severe grades of acute myocardial infarction the toxic levels and the serum level at death were significantly below that observed in normal control animals or where the degree of myocardial infarction was slight or in a healed state¹³.

Summary

The etiological factors, diagnosis, and treatment of hyper and hypokalemia have been discussed. The main etiological factor of hyperkalemia is anuria or oliguria, with or without high potassium intake whereas the main etiological factor in hypokalemia is decreased potassium intake with good renal output. The diagnosis of hyper and hypokalemia is confirmed by serum potassium determinations and by electrocardiography. The most efficient and durable method of treating hyperkalemia is by dialysis, whereas potassium deficiency is eliminated by the proper administration of parenteral or oral potassium.

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DISCUSSION

Joseph D. Heitger: Last month at the American Academy meeting in Chicago, Dr. Conn of the University of Michigan, gave us an excellent talk regarding the dangers in the use of ACTH. Among the dangers was a disturbance in potassium metabolism, which, in some instances, could become very dangerous.

Since ACTH is now more abundant and being prescribed more by physicians, the dangers accompanying its use should be called to the attention of the medical profession. The possible danger of its use must be kept in mind when it is prescribed. Perhaps the essayists can discuss this subject with a little more detail.

Martin H. Boldt: I would like to congratulate both speakers for their very excellent presentation of the subject. This is really a most fascinating subject because as a result of this we are now beginning to understand how digitalis works. Recent observations indicate that digitalis works by virtue of its ability to block the free entrance of potassium into the myocardial cells.

It is interesting, too, that the electrocardiograph effects of hypopotassemia and digitalis intoxication are very similar and, furthermore, that the clinical effects of hypopotassemia and digitalis are very much the same. Here, again, you see an indication of how a study of one element throws light on many fields in medicine; things such as digitalis which we have used for many years and are only now beginning to understand how they work.

J. R. Hendon: I would like to ask three questions:

(1) In your electrocardiogram you were able by the tracings to differentiate between a calcium disorder or imbalance and a potassium imbalance. I wonder if the electrocardiogram distinguishes between hypocalcemia and a pattern of hyperventilation syndrome or alkalosis.

(2) Would it not be fair to say that the adrenal cortex is intimately concerned with sodium and potassium metabolism rather than to suggest that its influence is on potassium alone? I mean by that that I wonder if we must not think of sodium and potassium as being reciprocal agents, and if thinking of those two elements in that way would not clarify our thinking on the situation a little bit.

(3) In an individual who is taking a pretty normal diet and does not have marked changes in excretory powers, do we have to worry about our potassium situation at all?

I am afraid I did not make my question clear. In a very sick individual who is taking a pretty normal diet and whose excretory facilities are not extremely damaged, do we have to worry about the potassium status in that individual?

Carlisle Morse: I want to emphasize the fact that potassium deficiency does not pertain to people who are still on an oral diet and it is only when you begin to get a lot of intravenous fluids that you get mixed up on potassium balance. In diabetic coma you can give all the insulin you want and will not get hypopotassemia unless you give a lot of glucose.

Herbert Clay: I enjoyed this excellent discussion very much. There is just one thing that has already been mentioned which I think is significant, and should be emphasized, and that is the changes in potassium associated with the use of cation exchange resins and particularly in view of the fact that these resins are being quite widely used clinically now. Hypopotassemia may develop in patients being treated with cation exchange resins even though they have as much as 20 or 30% potassium cycle in the resin, and we have observed this in our patients on cation exchange resin therapy. Individuals on diets with less than two grams of sodium may have five parts of potassium picked up by the resin for one part of sodium that is picked up by the resin. Whereas when the diet contains more than two grams of sodium the usual ratio is one and one-half parts of sodium to one part of potassium that is picked up by the resin.

With the use of potassium cycle exchange resins one occasionally runs into just the opposite of this and that is the development of hyperpotassemia. Hyperpotassemia is more likely to develop in those individuals on a potassium exchange resin who have a high sodium intake and poor renal function.

W. W. Pedigo (In closing): Dr. Heitger, ACTH and Cortisone administration in average dosage over a very long period of time may result in calcium and potassium deficit in the body. Osteoporosis may result with ACTH and Cortisone therapy and if osteoporosis exists before these drugs are administered, it is a relative contraindication. It is advised that potassium be given by mouth to prevent hypopotassemia if ACTH and Cortisone therapy is to be continued over any protracted period of time.

Dr. Hendon, I will attempt to answer your last question first.

In the presence of good renal function oral potassium is relatively safe even with large doses. This is not true with intravenous potassium which can be dangerous. If potassium is given too rapidly or in too large a dose intravenously, death may occur due to cardiac standstill. It is necessary to avoid having a high blood concentration of potassium reaching the myocardium. If a true intracellular deficiency of potassium exists and the patient cannot take potassium orally, then the slow intravenous administration of potassium is indicated. Not more than one gram an hour of potassium should be given intravenously except in very unusual circumstances and it is best given in a .1 to .2% solution by slow intravenous drip.

I would agree that we should think of potassium and sodium as reciprocal agents and we can better correlate our thinking by considering both electrolytes together.

The electrocardiogram with hypocalcemia is fairly characteristic with a prolongation of the Q-T interval with the S-T interval being the primary site of the prolongation with the T wave itself fairly normal. I am not aware of any characteristic electrocardiographic changes in the hyperventilation syndrome.

In an individual who is taking in a fairly normal diet and whose excretory facilities are not damaged, we do not have to worry about potassium deficiency.

R. S. Dyer, (In closing): Potassium can be given subcutaneously only in 0.1-0.2% concentration. However, hyaluronidase may make

subcutaneous administration more rapid and if potassium deficit is severe, 24 Gms of potassium may be given daily in drastic cases (1 Gm of potassium per hour is the maximum parenteral intake recommended). Frequent electrocardiograms should be taken to follow the course of therapy when such large doses are necessary. Usually only 3 to 9 Gms of parenteral potassium is required to correct acute deficits of potassium.

The parenteral fluids available on the market today at local hospitals are Abbott's Darrow Solution and Abbott's ampules of Potassium Chloride containing 20 and 40 milliequivalents. Darrow solution contains 1.3 Gm of potassium chloride per half liter together with sodium chloride and sodium lactate and is especially useful in the prophylaxis of hypokalemia, for example, in early post-operative states. No potassium should be given, however, until several hours post-operatively when the patient is out of shock and good renal output has been established.

For oral administration potassium nitrate and potassium chloride encephals 5 grains each are available. Potassium chloride is also in plain 5 grain tablets.

In diabetic coma it is felt that hyperkalemia should be watched for during the anuric phase and it is said by some 4, 6, 11, that hypokalemia should be guarded against during the use of large doses of insulin and parenteral fluids regardless of whether glucose and/or saline infusions are being used. Especially is this true since either type of solution may cause a sudden shift from hyperkalemia to hypokalemia when diuresis is established.

Surgical Pain: Its Importance and Clinical Management

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During the past decade unprecedented advances have been made in the knowledge of anatomic, physiologic, and psychologic phenomena involved in the sensation of pain; in basic pain mechanisms; in the clinical manifestations of pain; and in the nature of pain itself. The names of Livingston, Beecher, Wickler, Harold Wolff, Stewart Wolf, Hardy, Goodell, and others are prominently identified with recent advances in the knowledge of this important subject. Walter C. Alvarez has made valuable contributions to the understanding and clinical management of the so-called functional disturbances which cause so much distress and for which organic cause cannot be demonstrated.

Pain is only a symptom but its importance in the practice of medicine is of the first magnitude. The anatomic and physiologic mechanisms concerned in the perception of pain are relatively simple, but the effects of a painful experience on the patient are quite complex and in some cases may be serious.

Definition and Origin

In this discussion the word "pain" is used in its broad sense and means suffering from any cause. Its origin may be physical as in external injury, or mental as in fear, anxiety, worry, etc., or a combination of these factors may be present. The term "imaginary pain" is not justified. When this broad concept is applied it is not an exaggeration to say that pain and its sequelae dominate the very lives of many individuals. It is also apparent that a large majority, if not all, of the patients who seek medical attention do so because of the compelling influence of pain. This applies even to the healthy individual who requests a routine health examination, and to the perfectly healthy applicant for life insurance; the former has fear or anxiety concerning future illnesses which he hopes to avoid or postpone, and the latter is motivated by anxiety concerning the future welfare and security of his loved ones. In these cases the pain is indirect and perhaps subconscious but is present nevertheless.

Types and Characteristics of Pain

Two distinct types of physical pain are recognized: (1) Cutaneous or superficial, and (2) Visceral or deep.

Pain of cutaneous (superficial) origin is described as of "bright" or "brilliant" quality and, when of sufficient intensity, stimulates the primitive urge to fight or flight. Visceral (deep) pain, on the other hand, is quite different; it is of a deeper aching quality and may be associated with nausea. It induces depression and inactivity.

For many years it was thought that certain organs and structures were insensitive to pain and that they did not possess pain receptive innervation. It is well known, for instance, the gastrointestinal mucosa, particularly that of the rectum and sigmoid, is ordinarily insensitive to minor surgical procedures such as excision of biopsy specimens and the fulguration of polyps. Similar procedures involving the skin would be quite painful if attempted without anesthesia. Recent studies have shown that the gastrointestinal mucosa does indeed have a pain receptive innervation but normally its threshold for pain perception is so high that it is relatively insensitive. Certain pathologic conditions, however, such as those which produce sustained inflammation or hyperemia may lower the pain threshold to such a degree that it becomes pain sensitive to even minor stimuli. Under such circumstances normal peristaltic activity may produce pain.

The Sensation of Pain and Its Two Components

It is a matter of common observation that under virtually identical circumstances one patient will manifestly suffer severe pain and distress, while another will experience little or no discomfort. Physical pain as a sensation is usually associated with a reaction of displeasure or anguish the intensity of which varies between wide limits depending upon the individual concerned and the circumstances. These associated reactions of displeasure and anguish may dominate and confuse the picture.

Observation and study of these associated reactions led to the recognition, about ten years ago, of the fact that the sensation of pain really consists of two separate components:

1. Perception of pain.
2. Reaction to pain.

Distinction between these two components is important. Pain perception involves relatively simple and primitive conduction pathways, and is primarily a physiologic mechanism. Reaction to pain, on the other hand, is basically psychogenic, it is highly individual, and is modified by complex functions.

Thresholds for the Two Components of Pain

Recognition of the two component parts of pain stimulated the development of methods and devices for study, measurement and evaluation of each of these components.

The threshold for pain perception in healthy human subjects shows remarkably little variation. It is approximately constant for different individuals and for the same individual at different times and under varying circumstances. This threshold can be substantially raised by pain relieving drugs. According to the experiments of Wolff and Wolf five grains of aspirin may after two hours raise it thirty-five per cent, and one-fourth grain of morphine may produce a rise of seventy per cent. Hypnosis and strong suggestive influences may also appreciably affect this threshold.

The threshold for reaction to pain, unlike that for pain perception, varies between wide limits among different individuals and even for the same individual under varying circumstances. Reaction to pain (the opposite of tolerance) depends upon interpretation by the affected individual and what it means to him in the light of past experiences. The objective manifestations of pain may be modified materially by the degree of aversion and mental anguish experienced by the patient. This reaction pattern, like personality itself, is highly individual and is the resultant of the innumerable forces to which the individual has been subjected throughout life. Hereditary racial and familial characteristics, environmental and family backgrounds, childhood emotional experiences, and many, many other factors contribute materially to the physical

and psychologic complexities with which we have to deal.

The limitless number of variables which form the personality pattern make it, like the finger print pattern, distinctly individual and each different from all others. This explains why in a given situation no two human subjects will react in exactly the same way. It also explains why in the successful practice of medicine each patient is an individual problem and different from all others.

Clinical Factors and Methods in the Control of Pain

The control of pain is of serious concern to the physician not only because of humanitarian considerations. It is well known that physical pain and psychic trauma can be important etiologic factors in the development of organic disease. This is particularly applicable to the cardiovascular and gastrointestinal systems. The economic importance, however, of all such organic diseases is small indeed when compared with the tremendous total cost of functional disorders.

While my primary interest is in the specialty of proctology the principles of management of pain involving the rectal area are, with regional differences of minor importance, the same as for pain of comparable severity elsewhere. These same principles apply to pain of surgical nature in other regions of the body and also, with appropriate modifications, to pain of non-surgical conditions.

Factors Influencing Post Operative Pain

Surgical operations, especially those involving the anus and rectum, are almost invariably followed by some pain or discomfort. Such procedures can never be made absolutely painless where the sensory nerve pathways are intact. The degree of postoperative pain and distress, however, is materially influenced by several factors among which the following three are considered highly important:

1. The degree of skill and gentleness of the surgeon and his knowledge and application of accepted principles of surgery. This is especially true in rectal surgery. Painful secondary muscle spasm is proportional to the amount of tissue trauma inflicted.

2. Adequate and effective preoperative preparation and postoperative treatment on an individual basis including proper

local care of surgical wounds and the intelligent and adequate use of sedatives and pain relieving drugs.

3. The patient's threshold for reaction to pain and the degree to which the surgeon elevates this by sympathetic understanding and reassurance (psychotherapy).

Strict application of these principles will reduce postoperative suffering to a minimum.

The preoperative preparation of the patient, especially the psychologic conditioning, may be an important factor in determining the total amount of suffering he will experience. The tense hypersensitive type of individual will often exhibit objective evidence of anguish and distress at the thought of impending surgery. A French proverb says, "He who fears to suffer, suffers from fear." The discerning physician will quickly detect evidence of psychogenic distress and take immediate steps to correct it. The additional time required for this will be well spent. To understand the patient's personal problems as related to his illness, to secure his confidence, and to give him positive and convincing re-assurance and encouragement constitutes sound and practical psychotherapy. It is this phase of medicine in which "practice of the art" plays a highly important role and may determine, in the mind of the patient at least, the difference between satisfactory and unsatisfactory doctor-patient relationship.

Importance of Preoperative Medication

Proper preoperative medication is also important. Very few patients sleep well without a sedative the night before operation. Adequate sedation to produce restful sleep is highly desirable. Additional sedatives including an appropriate dose of morphine or equivalent drug should be given shortly before time of operation so that the patient will arrive in the operating room with his sense of critical perception so obtunded that he is in physical and mental repose. The more closely this ideal can be achieved the more satisfactory will be the operation for all concerned.

Postoperative Control of Pain

The control of postoperative pain and distress is from the patient's point of view a most urgent and important consideration and this is especially true following rectal surgery. The injection of long lasting anesthetic agents and other local measures to control pain may be useful

adjuncts when properly used. There is reason to believe, however, that the use of morphine or equivalent drug is now and will long continue to be highly desirable if not indispensable in the adequate and effective control of pain and distress in the majority of patients who are subjected to surgery of any consequence.

Value of Morphine

To obtain maximum benefit from morphine, or equivalent analgesic drugs, its physiologic and pharmacologic effects must be understood and appreciated:

1. Morphine (or equivalent) has two principal physiologic effects both of which are important and valuable: first, it produces a definite increase in the ability to tolerate pain, and second, it produces euphoria, allays fear and apprehension, and promotes a sense of well-being.

2. The euphoric effect of morphine is valuable in the control of pain because it produces a substantial elevation of the threshold for reaction to pain and this, in turn, augments its analgesic effect.

3. The presence of severe pain will diminish or completely nullify the effects of ordinarily effective doses of morphine. Thus a small or moderate dose given before or when discomfort begins, may be more effective than a large dose given later after the pain has become severe.

4. The presence of pain reduces or, if the pain is severe, eliminates the euphoric effect of morphine with a corresponding decrease in addiction tendency. When morphine is used sensibly, though adequately, for relatively short periods of time, as postoperatively, there is little if any likelihood of habit formation.

It has been my experience that the average postoperative patient can be kept reasonably comfortable if a substantial dose of morphine is given when he first notices discomfort. This is repeated every hour if relief is not complete. When given in this way a total of from one to three or four doses will usually be sufficient for the average patient. In exceptional cases in which complaints of pain are difficult or impossible to control due caution must be exercised to avoid toxic effects. A good general rule is to withhold morphine if the respiratory rate is depressed to fourteen or less per minute. In unusual instances in which severe pain develops before a hypodermic is given the judicious intravenous administration of morphine is more rapidly effective.

Postoperative Rectal Pain

Postoperative pain in the rectal area is caused largely by muscle spasm. Moist heat applied in the forms of packs or sitz baths has a relaxing and comforting effect which is welcomed by the patient. Cleanliness and adequate drainage of open surgical wounds must also be assured by appropriate daily postoperative care.

If pain can be controlled or prevented for eighteen to twenty-four hours following rectal and other painful types of surgery, it is probable that the patient will have little or no further need for morphine. One-half grain of codeine with five or ten grains of aspirin by mouth is an effective analgesic and when given every two to four hours will control discomfort or mild pain.

The use of pain relieving drugs should never be considered as a substitute for skillful and efficient operative and post-operative care. The proper and judicious use of these drugs may contribute ma-

terially to the patient's comfort but their use is at best only adjunctive to basically good surgical practice.

Intractable Pain

To make this discussion more complete I would like to add a few words concerning the chronic and sometimes intractable forms of pain such as that of facial neuralgias, causalgia, phantom limb pain, metastatic bone lesions and some terminal phases of neoplastic diseases. The unfortunate victims of these conditions often present problems of altered and perverted patterns of sensory preception and pain reaction which may well tax the combined resources and ingenuity of the internist, the neurosurgeon and the neuropsychiatrist. It is encouraging, however, to observe that great progress is being made, especially in the fields of pharmacodynamics and of neurosurgery, so that many of these pain-ridden patients can anticipate relief and hope rather than discouragement and despair.

The Relationship Between Rectal Polyps and Rectal Carcinoma

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Introduction

In a recent Cancer Bulletin¹ it was estimated that 16,367 United States Citizens would be seen in 1950 with Cancer of the Rectum. The American Cancer Society earnestly hopes that you, or some physician, has seen the majority of these patients at an early stage of their disease when the opportunity for cure is greatest. We are all aware that a trend towards earlier diagnosis of all accessible malignancy has been largely instituted through the efforts of the American Cancer Society. The public has eagerly grasped the opportunity to attend Cancer Detection Clinics. Physicians must recognize this public effort and participate in this trend. I, therefore, suggest to you, to the American Cancer Society and to the public a simple slogan, "Polyp Detection is Cancer Prevention."

Incidence

The incidence of any disease is of importance in general practice when it has attained a sufficient numerical frequency to attract attention to it. The familiar phrases such as, "I never see these things" or "My patients rarely develop such trouble" are known to all of us. Therefore, if we are to get at the root of the polyp detection problem, we must present evidence that, "Your patient does develop such trouble" and that "You can see these things."

Some of the questions and some of the answers relative to this problem will be discussed.

The first question that arises might be as follows: As a general practitioner, subscribing to the idea of "Every Doctor's Office a Cancer Detection Clinic," how often might I find a polyp in the rectum or colon? My time is limited and my patient load is heavy, but should I decide to proctoscope patients, how often will I see

¹Read before the Fifth Annual Cancer Symposium, Kentucky Division, American Cancer Society, Louisville, November 8, 1951.

these things? Will the added work be worthwhile?

A partial answer to this question is demonstrated by reports from several Cancer Detection Clinics. In 1949 Ort-mayer and Connelly² proctoscoped 1,014 well women at a Cancer Prevention Clinic in Chicago and found polyps in 1.8 per cent. Greer³, of Washington, in 1950 reported an incidence of 3 per cent in 747 patients who had routine proctoscopic examinations. From a Minneapolis Cancer Detection Clinic, Christianson and Tenner⁴ reported in 1951 that in a 2 year period 2,226 new patients were examined procto-scopically and 1,039 returned for re-ex-amination. Adenomatous polyps were found in 274 cases or 12.3 per cent of new patients examined and in 79 cases or 7.6 per cent of re-examined patients. At the Strang Cancer Prevention Clinic in New York City, Binkley⁵ in 1948, reported an incidence of 6.4 per cent in 2,912 cases ex-aminated proctoscopically.

Here then, is a partial answer to our question. It is a sample of what is being found in clinically asymptomatic patients who are subjected to proctoscopy at Can-cer Detection Clinics.

A second question that is of interest per-tains to the incidence of adenomatous polyps in clinically asymptomatic pa-tients who go through a general diagnostic clinic. It has been difficult to obtain and evaluate reports dealing with this. How-ever, the illuminating 1951 report of Young⁶ will provide a partial answer to this question. Of 509 new clinically asymptomatic adult patients who were routinely proctoscoped during a diagnostic survey at the Yater Clinic, 44 or 8.8 per cent had polyps of the lower accessible bowel. None of these were detected by digital examination. In 1950 Hauch⁷ re-ported an incidence of 8.1 per cent in 1,919 asymptomatic patients examined at the Mayo Clinic. This incidence closely parallels that reported by Young.

This again is a partial answer to the question of how frequently one might ex-pect to find polyps in patients subjected to proctoscopy as a part of a general diag-nostic survey.

A third diagnostic feature, related to in-cidence, pertains to the frequency with which adenomatous polyps are detected by Proctologists. Presumably all of these patients have clinical symptoms of ano-rectal or colonic disease and, for that rea-

son, the family doctor has sent them to the Proctologist. In 1951 Castro⁸ reported an incidence of 2.4 per cent in 12,000 procto-scopic examinations done by our group. This is a low incidence compared to 10.8 per cent in 640 proctoscopic examinations reported by Green⁹ in 1941 and 14.9 per cent in 256 proctoscopic examinations re-ported by Fansler¹⁰ in 1948.

Chart 1
Incidence and Detection

C.D.C.	D.C.	Pr.
1.8%	8.8%	2.4%
3.0%	8.1%	10.8%
12.3%		14.9%
7.6%		
6.4%		
8.2%	8.4%	9.7%
8 to 10 percent		
C.D.C.—Cancer Detection Clinics; D.C.—Diagnostic Clinics; Pr.—Proctologists		

My purpose in citing these statistics to you is to lend emphasis to the problem of polyp detection. It is evident that more people harbor these potentially malignant lesions in the accessible portion of the rectum and colon than we heretofore sus-pected. One would not have too much difficulty in supporting the opinion that perhaps 8 to 10 per cent of individuals over 40 years of age have adenomatous polyps in their lower bowel. There is increasing statistical evidence to support this viewpoint. Nor would one be indulg-ing in fantasy to presume that in patients having clinical symptoms of anorectal or colonic disease an incidence exceeding 10 per cent will be confirmed as reports ac-cumulate.

Therefore, if you will accept the broad implications this 8 to 10 per cent incidence indicates, it becomes evident that procto-scopy should be performed more frequent-ly by the family doctor. Polyp detection thus becomes a rewarding experience which is distinctly worthwhile. It should be a mandatory requisite for patients sub-jected to a general diagnostic survey.

Diagnostic Features

We have spent some time on the inci-dence of polyps of the colon and rectum for practically all reports indicate that ap-

proximately 75 per cent of these lesions have been found only because a proctoscopic examination was performed. The well known symptoms of blood in the stool, a bloody mucoid discharge, an alteration in bowel habits or stool character, a prolapsing mass or a localizing colicky abdominal discomfort has been present in 25 per cent or less, of patients thus diagnosed. Of the 352 adenomatous polyps discovered in the 270 patients reported by Castro⁸ for our group, only 67 were diagnosed or suspected by the referring physician. Of the 44 adenomatous polyps discovered in the 500 patients examined by Young⁶, none were detected by digital examination. These, and other reports, make it abundantly clear that we cannot wait for the appearance of symptoms to constitute an indication for a proctoscopic examination. Therefore, I urge you to think beyond the desirability of a digital examination for these patients and to consider the necessity of a proctoscopic examination for polyp detection.

Figure 1

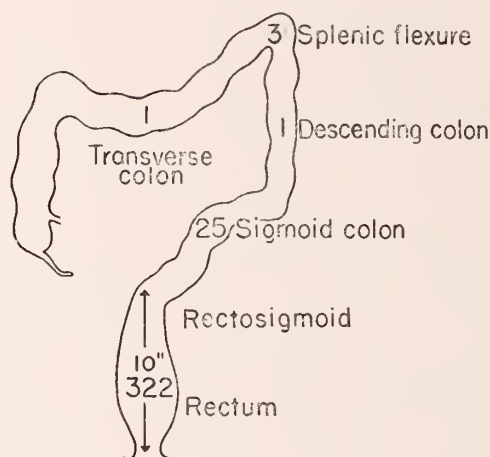


Fig. 1. Locations of 352 adenomatous polyps observed in 270 patients.

(By permission of Surgery, Gynecology and Obstetrics)

Figure 1 will illustrate the location of 352 adenomatous polyps observed in our series of 270 patients. You will note that 322 adenomas or 91.5 per cent were visualized and 30 adenomas or 8.5 per cent were demonstrated by roentgen study. If I were to pick out the most important clinical symptom or finding of these 30 polyps located beyond reach of the proctoscope, I would emphatically state that blood in or on the stool would be it. Regardless of whether this is detected by the patient or seen during examination, it is

the outstanding finding for polyps beyond the reach of the proctoscope or sigmoidoscope.

Chart 2

Diagnostic Features

Symptomatic Polyps	25%
Asymptomatic Polyps	75%
Accessible to Proctoscopy	90%
Demonstrable by X-ray	10%
Less than 10% palpable	

The roentgen demonstration of polyps at a higher level is ordinarily not too difficult. I would caution all concerned that a single roentgen demonstration of a lesion is ordinarily not sufficient evidence to warrant laparotomy. Most Proctologists will want a second confirmatory barium enema before operating. In some instances several barium enema studies are necessary to demonstrate the lesion. Under these circumstances extreme patience is required of the host and great diligence is necessary on the part of the Roentgenologist.

Rectal Polyps and Rectal Carcinoma

In 1940 Martin¹¹ of Louisville stated that the great majority of polypoid lesions of the colon and rectum, if allowed to remain in situ, would become malignant. Most physicians will subscribe to this philosophy for we are dealing with a lesion whose location in the bowel closely parallels that of malignancy. However, two rather important questions arise if one subscribes to this philosophy. First—What percentage of polyps are malignant when first seen and removed? Second—What evidence is there that malignancy develops from polyps?

In our series⁸ of 352 adenomatous polyps 53, or 15 per cent, showed evidence of malignancy. In Green's⁹ series of 70 adenomatous polyps 10, or 14 per cent, showed evidence of malignancy. These 2 reports indicate the malignant status of adenomatous polyps when they are first seen and removed.

In answer to the second question, there is ample evidence that malignancy develops from adenomatous polyps. Westhues¹² in 1934 demonstrated that 15 per cent of the malignancies of the colon and rectum definitely arose from adenomas and an additional 34 per cent probably had their origin in adenomas. Swinton

and Warren's¹³ report of 1947 demonstrated that 14 per cent of 827 cases of cancer of the colon and rectum developed from adenomatous polyps. Bacon¹⁴ in 1951 reviewed 800 cases of carcinoma of the colon and rectum and presented evidence that 90 or 11.25 per cent had their origin in adenomatous polyps and 30 or 3.75 per cent had presumptive evidence of having originated in an adenomatous polyp. There are other reports available confirming these statistics.

Chart 3
Polyps and Carcinoma

Polyps	% Malignant
352%	15%
70%	14%
Carcinoma	Polyp Origin
827	14 %
800	11.25 %
...	15 %

We are thus prepared to state that approximately 15 per cent of all adenomatous polyps show evidence of malignant change when they are first seen. Furthermore, there is evidence that approximately 15 per cent of all malignancy of the rectum and colon has origin in adenomatous polyps. Presumptive evidence of an additional 15 per cent of rectal and colonic malignancy arising in polyps is available.

Conclusions

A massive array of statistical evidence is thus available that will permit us to draw the following conclusions:

1. It is entirely possible that 8 to 10 per cent of individuals over 40 years of age have adenomatous polyps in their lower bowel.

2. Only 25 per cent of these individuals have symptoms of anorectal or colonic disease constituting an indication for proctosigmoidoscopy or roentgen study.

3. In 75 per cent of these individuals adenomatous polyps will be detected only because routine proctoscopy or roentgen study is carried out through the efforts of Cancer Detection Clinics, Diagnostic Clinics, Proctologic or other studies.

4. Approximately 15 per cent of all polyps are malignant upon initial detection.

5. Approximately 15 per cent of all colonic and rectal malignancy show evidence of having originated in an adenomatous polyp.

6. There is presumptive evidence that an additional 15 per cent of colonic and rectal malignancy have had their origin in adenomatous polyps.

Chart 4
Conclusions

Incidence (over 40)	10%
Symptomatic	25%
Asymptomatic (Pr. -X-ray)	75%
Polyps Malignant	15%
Malignancy of Polyp Origin	15%
Malignancy of ? Polyp Origin	15%

In conclusion it should be sufficiently clear that "Polyp Detection is Cancer Prevention." I am sure that the performance of routine proctoscopy by a greater number of physicians will increase the frequency of early detection, early diagnosis and early treatment. This should be a rewarding experience in which more physicians can participate with justifiable pride if they will make their own office a Cancer Detection Clinic.

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The Early Detection of Gynecologic Cancer

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Paducah

It has been stated during this year that there are now available the means of saving 90% of women afflicted with gynecologic cancer.

This is a theoretical figure, of course, and would require perfect application of known techniques of diagnosis and treatment to all women of the community, a virtual impossibility. However, the background of this remarkable statement is of the first importance to every physician. I shall try to present this background tonight.

For the sake of brevity, percentages will be expressed without decimals, and extended quotation of authority will be avoided. However, my debt to Corscaden's "Gynecologic Cancer" will be apparent to any one who reads it.

Curability

Our aim in cancer work is, of course, to cure it. The question of curability can be approached from several angles, and these must be appreciated in any discussion of the disease. For example we are accustomed to the "5 year cure rate," indicating that the patient is free of subjective or objective evidence of cancer after an interval of five years. It is never possible to say that all cancer cells have been removed or destroyed.

The gross cure rate is the five year cure rate obtained in the general population including all cases with and without treatment.

The absolute rate is that obtained in the same class of patients in a well conducted clinic. This includes all cases admitted, early lesions, late lesions, and advanced untreatable cases.

Using these terms, we find that cancer of the cervix, which constitutes 11 per cent of all cancer, has a gross cure rate of only 25%. The absolute cure rate rises to 40%. However (and here is where early diagnosis appears) cases in which the lesion is limited to the cervix have a cure rate of 70%; where the lesion is less than 1 cm in diameter but still recognizable by ordinary diagnostic methods

85 to 90% are cured, and when the lesion is subclinical, that is, discovered by accident or screening tests, the cure rate is 100%.

Cancer of the corpus, which constitutes about 8% of all cancer, has the same low 25% gross cure rate. When treated properly and diagnosed early, the absolute cure rate is 85%. The average national figures for absolute cure in unselected cases are with radium 50%, with operation 60%, and combined 75%.

Cancer of the ovary, which constitutes 6 per cent of all cancers, has a gross cure rate of 20%, and the absolute cure rate is only 7% better. This is in part due to the fact that it is a relatively neglected tumor, and in part to the fact that it lies on the borderline between the classification of accessible and inaccessible cancer. The matter of accessibility is of interest, because accessible cancers are commoner than inaccessible, and a high cure rate in a disease which is common is more important than in a rare disease.

Broadly speaking, the accessible cancers are gynecological, breast and skin, and they constitute 60% of all cancers. Their gross cure rate is 25% and their absolute rate 80%, compared with only 2% of gross cures in inaccessible cancers, and a 25% absolute cure rate.

Percentages are hard to follow by ear, so let me repeat myself in different words. Enough is known to cure 80% of easily available cancers in actual recorded practice, but nationally speaking we are only curing 25% of them. The attack on the less available cancers has not progressed as far—under ideal conditions only 25% of them are cured, and nationally speaking we are only curing 2% of them.

Value of Early Diagnosis

It is obvious that the appalling spread between cures obtained in medical centers and over the country at large is due to more than superior therapeutic skill. It is largely due to early diagnosis.

It is particularly true of cancer of the female organs that time is the controlling factor in diagnosis. It would be undesirable to delay a few weeks in the diagnosis of pernicious anemia, diabetes, or

other insidious diseases, but such a delay would not be as likely to jeopardize the patient's life. Such a delay in cancer may well spell death.

Causes of Delayed Diagnosis

The causes of delay in diagnosis of gynecologic cancer have been studied in the Philadelphia area.

There was unnecessary delay in 75% of diagnosis of 1100 cases of pelvic cancer, and the patient was wholly or in part responsible in 56% of these cases.

This patient delay was investigated. It was found that ignorance of the significance of uterine bleeding played only a small part. The important factor was fear, either conscious or unconscious, of facing a diagnosis which the patient believed to be a death sentence.

Patients do not see cured cancer cases as such because cured cases keep quiet about it. Those who are cured of cancer are still considered queer. J. Marion Sims, the father of gynecology and founder of the Woman's Hospital, was removed from the staff in 1882 because he insisted on treating gynecologic cancer in that institution. This action was taken by the wealthy patronesses of the hospital, and I mention it because to a great extent that attitude is prevalent today. It is an attitude that must be combated, and we physicians are under an obligation to help fight it.

Four Point Program

A four point program for overcoming the 56% delay in diagnosis of pelvic cancer due to the patient's procrastination has been suggested as follows:

1. Cancer should not be discussed as a generalized disease. The poor results in the 40% of inaccessible cancers should not be allowed to obscure the good results in the 60% of accessible cancers. The curability of cancer must be demonstrated by the actual presentation of cured patients with the formation of cured cancer clubs or other devices.

2. Women, physicians, and the community in general must be made to realize that the examination of the female genital organs is a part of the general physical examination. Where this policy has been carried out, it has been found possible to educate young girls to have a rational attitude toward the sex organs with the elimination of embarrassment.

3. Patients should report all vaginal bleeding which, (a) during the child-bearing era, continues beyond the next menstrual period, and, (b) exists at all post menopausally.

4. Promotion of the idea of routine systematic examination of symptomless women either by individual physicians or by cancer detection clinics, (in which are discovered 10 non cancerous diseases to one cancer).

Delay Due to Physicians

The Philadelphia group found that the physician was responsible for delayed diagnosis in 27% of cases. The duration of delay broke down as follows:

Cervix	7.4 months
Fundus	13.7 months
Ovary	9.6 months
Vulva	19.0 months

In the last two groups, the physician failed to examine the patient in 62% and 71% of cases respectively, and the over all neglect of vaginal examination was 50%.

A breakdown of the causes of physician delay is so important to us all that I shall list them in order of importance.

No examination made

Examination made, wrong diagnosis

Oral medication and hypox

Local treatment of cervix with biopsy

Douches

Told it was menopause

Diathermy

Rest

Examination deferred until bleeding stops

Examination to be made if bleeding recurred.

Further reasons for failure to diagnose early, reported separately from the Philadelphia study, are:

Cases in which two lesions coexist, one benign and obvious, as fibromyomas, polyps and erosions.

Eight per cent of cancers of the cervix in one large hospital series were in stumps remaining after supravaginal hysterectomy. Only half of these could be classified as true stump carcinoma. The other half were discovered within 2 years, and had been overlooked.

With this summary of the extraordinary possibilities for improved cure rate inherent in the early diagnosis of gynecologic cancer, and an appreciation of the part

played by the patient and physician respectively, let us investigate the process of early diagnosis in brief detail.

Process of Early Diagnosis

The recognition of pre-invasive cancer as a clinical entity should underlie our thinking. Cancer starts as a local disease, a collection of cells so similar to the normal that the older pathologists (and some of those now working) denied the existence of a demonstrable cancer cell. However that may be, somehow these cells have acquired this abnormal quality and appearance, and may lie quiet for years (as long as 8 years, for example, in intraepithelial cancer of the cervix) before they exhibit the next manifestation of malignancy, which is that of invasion. The basal membrane is broken through. The growth has become "early invasive."

Still there is no bleeding, because the covering epithelium is intact. Only when this is broken through will there be any discharge or bleeding, and bleeding is therefore a manifestation of ulceration, a late change, rather than a true symptom of the underlying cancer. We must teach the layman to report bleeding promptly, but our own efforts should be directed to the diagnosis of cancer before bleeding appears.

While bleeding is a late symptom, it is nevertheless the only significant one in gynecologic cancer until the very late, usually hopelessly late, observation by the patient of a mass or ulcer. Vaginal bleeding from cancer has no reliable symptoms which differentiate it from benign organic or functional bleeding. Therefore every case of abnormal vaginal bleeding must be considered cancer until proven otherwise, and surely the figures given at the beginning of this paper will substantiate the point.

In the attack on early cancer in the pelvis, a considerable battery of tests has been developed. The ones to be discussed here are:

- Dilatation & Curettage
- The Papanicolaou smear
- The coning biopsy
- The scraping biopsy
- The sponge biopsy
- The excision biopsy
- The Schiller test.

Dilatation and Curettage

Dilatation and Curettage should be performed on every case of abnormal uterine bleeding. There is no way to rule out carcinoma of the corpus. We have seen that the bleeding itself is an unreliable guide, for even pure menorrhagia with no intermenstrual bleeding at all can occasionally result from carcinoma. Coincidental lesions are a dangerous screen, and curettage will eliminate most of them. Hysterectomy is no substitute for curettage because too many series reveal a significant incidence of undetected cancer in uteri removed conservatively, and conversely, a negative curettage can justify conservatism where benign conditions are present. For these reasons routine preliminary curettage is mandatory before hysterectomy in many centers. Finally, a wider use of dilatation and curettage would help reduce the one third of unnecessary pelvic laparotomies performed in this country as reported by Miller, officially accepted by the A.M.A.

Papanicolaou Smear Test

The Papanicolaou smear is now established as a standard procedure. It was accepted as such by the Fifth International Cancer Congress meeting in Paris in 1950.

There has been such an enormous literature on the vaginal smear, and the controversial aspects of its use are so well known, that I am at something of a loss to know where to start discussing it. Probably the best approach is to consider what it will and will not do.

The vaginal smear is a screening technique for routine use in asymptomatic individuals. It is not a definite test for cancer, but is designed to select those individuals in whom there is no indication for cervical biopsy or dilatation and curettage except that they have had one or more positive smears. The test, reported from all over the country in tens of thousands of cases, has an accuracy of 90 per cent in carcinoma of the cervix, and 80 per cent in carcinoma of the corpus.

The underlying principle of the test is the continual desquamation of superficial cells from the cervix, endometrium, and occasionally the Fallopian tube, which then collect in the vaginal pool. Since very early carcinoma is more likely to avoid biopsy techniques due to its small

size, and at the same time has less necrosis, and therefore better nourished and better preserved cancer cells, the vaginal smear has been found more accurate than biopsy in detection of carcinoma in situ by both Graham and Meigs in Boston and Ayre in Montreal. The combination of the two techniques, biopsy and smear, has been reported to give an error of less than 2 per cent, as compared to 12 per cent for smear alone and 30% for biopsy alone in this type of cancer.

The vaginal smear has another legitimate area of usefulness in the following of post-irradiated cases of cervical carcinoma. The smear showing radiation effect is characteristic, and these effects subside, while persistence or recurrence of malignant cells makes possible early further treatment, either re-radiation or radical surgery with lymph-node dissection. This does not, however, come within the field of early diagnosis.

The standard method of obtaining these smears is to insert a dry speculum to expose the posterior fornix. The presence of water will change the appearance of the cells, so not only should all instruments be dry, but the patient should not have douched for 48 hours. A specimen is sucked from the posterior fornix into a wide-mouthed pipette, and a second one from the cervical canal by a narrower pipette. The smears are made immediately, and placed in a solution of equal parts of alcohol and ether for $\frac{1}{2}$ hour. They can then be stained and read, or, while still wet, a drop of glycerin can be placed on the smear, a second slide laid upon the first, and the "glycerin sandwich" as it were can be mailed in an ordinary slide mailer. The manipulative part of this procedure need not consume 5 minutes.

Numerous modifications of the above technique have been developed, and at the present time standards are being adopted for a more uniform technique, both as to collecting, staining, and interpreting the smears. Universal adoption of these standards is expected to increase the percentage of accuracy above the current figures. A national organization exists for this purpose.

It is time to say something about the drawbacks of the Papanicolaou smear. The one most commonly quoted is the degree of training required to read them, and the length of time required to examine each slide (10 minutes). This is a real objec-

tion, and is being met in two ways. Accuracy has been found higher where the reading was done on a full-time basis, and with the slide-mailing technique it has become possible to set up reading centers throughout the country. Such a center has recently been established at the cancer institute of the University of Tennessee in Memphis. The Vincent Memorial Laboratory in Boston pioneered in the use of relatively large numbers of technicians to screen out the obviously negative smears, with all others being read by higher echelons. Their accuracy was unimpaired as confirmed by biopsy and follow up, and schools for the training of such technicians are being set up at points throughout the country. I understand such a school is starting in Memphis this year. It seems likely, therefore, that as the proper use of the vaginal smears increases, facilities for reading them will improve and keep pace.

Another objection is to the margin of error. However, failure to detect 20% of asymptomatic corpus carcinomas does not leave those individuals any worse off, and raises the cure rate on the other 80% to the 100% area.

The expense involved is a factor. It is certainly higher now than it will be. Reading fees are from \$5.00 to \$10.00 on a private basis. The medical centers give figures of from \$75.00 to around \$200.00 as the cost of detecting an early cancer, somewhat less than the price of a cheap coffin.

Among the modifications of the smear, scraping of the cervix with a wooden spatula (Ayers technique), use of a cotton applicator in a paper sheath, (somewhat similar to the principle of the Tampax tube) (Kraushaar technique) and the use of fluorescent stains (Friedman stain) should be mentioned.

Coning Biopsy

The Coning Biopsy was introduced by Gusberg in February of this year. This test is based on a gadget, but a good one. It is now possible to take a circumferential sample of the entire squamo-columnar junction by a simple office biopsy procedure. Except in the grossly abnormal cervix, which is dealt with by tests to be described, this relegates the punch biopsy to a subordinate status, since no areas of this critical site are missed. Not only does this furnish a sound method for further documenting the vaginal smear, but it also

gives another type of screening procedure.

Gusberg's group made a survey of women over the age of 35 years with symptoms of uterine cancer. The patients were selected from the general hospital diagnostic clinic by exclusion of those with any aberration of menstruation or history of abnormal uterine bleeding and with no suspicion of cancer on pelvic examination. In their series of 500 cases they found 10 intraepithelial cancers (2%) and 10 cases of basal cell hyperplasia, who would, of course, be candidates for meticulous follow-up.

I would like to quote Gusberg at this point. "There is no doubt that preclinical cervical cancer can now be discovered in a significant section of the female population by techniques now available to us. There is no longer much doubt that these lesions are truly malignant. We do not know how long it will take any individual lesion to invade, and it may be possible that in rare instances a patient might live out her lifetime without further advancement of the disease. It is clear, however, that the sooner we school ourselves to this evolutionary concept of cervical cancer, and adjust our diagnostic methods accordingly, the greater will be our reward in preventing such lesions from progressing to a stage where treatment is complex and frequently fails. The fact that it is possible to overtreat or mistreat patients with borderline or seedling lesions should in no way distract us from our search for these lesions and their precise definition. Certainly, no gynecologist who has watched his patient die of uncontrolled cervical cancer could seriously doubt the many advantages of enthusiasm for cervical biopsy."

Scraping Biopsy

The Scraping Biopsy done by the Ayre method already mentioned, the sharp spoon of Novak, or the cone-shaped rasp of Miller are all based on forcible desquamation of cervical epithelium. The cells are smeared out by the Papanicolau technique. A combination of the coning biopsy and the vaginal smear will give a better picture with fewer false positives.

Sponge Biopsy

The Sponge Biopsy in which a suspicious lesion of the cervix is scrubbed with a gelfoam sponge, and the sponge subsequently sectioned, has the great advantage

that it can be read by a pathologist without special cytological training. One report on this technique by Gladstone claimed 100% accuracy in a series of accessible cancer throughout the body. He points out that it is preferable to punch biopsy in erosions, since no part of the surface is neglected. It cannot, of course, substitute for the vaginal smear, since it does nothing about the endometrium. This is another relatively young technique which requires and deserves further study.

Excision Biopsy

The Excision Biopsy is the old faithful, and it actually includes the coning biopsy. Along with dilatation and curettage, it is the definitive test for gynecologic cancer.

The number of cervical biopsy punches is legion. In this connection, it must be emphasized that the high frequency loop biopsy is dangerous and obsolete, because there can never be assurance that an area of preinvasion has not been cooked, and local cauterization is not the procedure of choice in these lesions.

It is superfluous to continue about the importance and technique of excision biopsy, but I would like to emphasize this, a biopsy is significant, for that piece of tissue only, and a single piece of tissue may give a tragically false sense of security. This point leads to the final test for discussion. It is an old one, once neglected, and now coming to the fore.

Schiller Test

It is the Schiller test, which depends on the ability of the normal squamous covering of the cervix to take up iodine. The cervix is swabbed with watery Lugol's solution, and the normal areas turn brown, while abnormal areas remain unstained. The widespread belief that this was a direct test for cancer caused it to become discredited. It is not. It is for the sole purpose of revealing those areas, particularly in the region of the external os, from which a biopsy should be taken. As such, it belongs in the examining room of every physician handling female patients.

There are a number of other tests applicable to the detection of pelvic cancer, some of them dangerously inadequate, like suction biopsy, others experimental such as Langman's cervical polarity test. However those described are the fundamental ones.

Armamentarium For Early Diagnosis

Should every physician adopt the full armamentarium for early cancer diagnosis in the pelvis, with all the time and expense to the patient that is entailed? Greentree, and an increasing number of others believe not. They emphasize prevention, as regards the cervix at any rate, this despite the possibility of cauterizing an existing carcinoma which was listed as a cause of delay by the Philadelphia group. The reasoning is as follows. Pemberton and Smith were unable to find a single case of 669 with carcinoma in whom the cervix had been cauterized before the onset of cancer. Another series at Ohio State University Hospital showed that none of 225 cases of carcinoma of the cervix had had previous cauterization. Furthermore, the famous Macfarlane experiment at the Woman's Medical College of Philadelphia, extending over a period of 13 years, gave the following result:

1319 presumably well women started the experiment by submitting to pelvic examination twice a year. 666 were still coming 13 years later.

3 cancers were discovered at the first visit 13 years ago.

In the next 13 years, only one other cancer of the cervix was discovered.

239 inflammatory lesions of the cervix were eliminated during this period.

The conclusion is that prophylactic care prevented several cancers.

I am not reporting or advocating that casual office electrocoagulation be substituted for greatly increased effort at early diagnosis. It is every physician's responsibility to continually review recent knowledge, and formulate and adopt a policy consistent with that knowledge. But the facts do indicate that early detection and prophylaxis go hand in hand, with prophylaxis perhaps a little in the lead.

Ovarian Tumors

I have said little about ovarian tumors. The case can be put very briefly. Allan and Hertig report on the size of ovarian tumors when first examined. Five per cent were less than 5 cm., 35% were between 5 and 15 cm., 60% were over 15 cm. in diameter. It seems reasonable that palpation of the adnexa was neglected for a long time in many of these cases.

Summary

If there have been too many percentages in this presentation, I am sorry. The early detection of gynecologic cancer depends upon each physician. It depends upon routine examination of the symptomless patient, just as the dentists and chest men do. It depends upon the judicious and faithful use of the relatively simple techniques described. It depends enormously upon teaching women the astonishing news that in many places today 80% of them are being cured of female cancer, and that here in McCracken County 90% of them can be cured.

Special Article

"The County Society's Relation To Blue Shield"

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St. Louis

For a Missouri doctor, it is partly a pleasure and partly a challenge to come to Kentucky. The pleasure, I am sure, requires no explanation. As is often the case with near neighbors, we in Missouri do not have so frequent and so close a contact with you in Kentucky as we could wish, and it is on that account always a pleasure to pay you a neighborly visit.

The challenge I feel in coming to speak to you—particularly on this topic which relates to the task of grassroots medical organization—would, I am sure, be felt by any doctor from any other state. I have the impression that you Kentuckians have established a sort of tradition for directing the affairs of organized medicine in this country and that you have a very special record of achievement in placing your members in the highest office of the American Medical Association.

I shall not be the least bit surprised or disappointed, therefore, if you conclude there is very little that I as a neighbor can tell you about the responsibilities of the county medical society, and if you feel further with some emphasis that no Missourian can possibly say an instructive word to a Kentuckian on the subject of medical organization.

For what it may be worth, however, I am going to give you my conclusions—based on many years of experience—on the stake each one of us as an individual doctor has in working with his local medical society to make a success of voluntary health insurance.

At the present time it might seem that the medical profession in America has little to fear from those government planners who would impose upon us a system of medical servitude under a program of compulsory health insurance. The results of recent elections—and the polls of popular views on the subject—might appear

to have made it clear that the American people are opposed to any system of state medicine.

It might seem that the efforts of organized medicine to obtain public understanding of the benefits of a free medical profession had succeeded. We might be excused for feeling that expression of this public understanding in recent balloting had settled once and for all the question of whether or not medical practice in America were to remain in the same voluntary condition that has been so important an element in the progress of medical care in this country—progress unmatched by that of any nation in the world. This is a time when we doctors might be excused for believing that we had won a victory.

On the other hand, we have clear evidence that the opponents of the traditional voluntary American way in medicine have not given up the fight. It appears that the membership of a group newly appointed by the President to study all aspects of medical care in the nation is heavily weighted with persons whose views are sharply divergent from the views of our profession. It seems clear that our success to date in resisting pressures for compulsory health insurance is not a final victory.

The plain fact of the matter is that we have achieved nothing more than a truce—a breathing spell—a new opportunity to demonstrate to the American people that our voluntary institutions in medicine are the best instrument for the service of all Americans.

The present state of the issue gives us an opportunity. It also poses for us a great danger. And this danger is intensified by the unsettled and unpredictable state of affairs in the world. It seems inescapable that in the next few years the American people will voluntarily submit to all the government planning and direction that is necessary for the effective

mobilization of our forces to defend freedom throughout the world. I emphasize this statement in full recognition that the present year may see a change in the national political picture. The fact is that whether a Republican or Democratic administration is elected, the cold war will continue, and every element of national planning incident to mobilization will necessarily continue as well.

From medicine's point of view, this condition is fraught with danger. It means inevitably that great numbers of physicians will continue to be called from their normal practice because of the needs of the military forces. The result may prove a serious complication of the problem of providing proper medical care for our population at home.

An important and critical part of this problem must, necessarily, be—as it has been in the past—the question of how medical care is to be financed. We are entering a period of severe inflationary pressures and of unquestionably higher taxes. The question of the cost of medical care as an element in the cost of living will be increasingly important.

In this emergency period, moreover, all Americans will become increasingly accustomed to acquiescing in government plans for directing the economy and for allocating the distribution of goods and services.

I think it not necessary to labor this point. It must be obvious to all of us that this breathing spell we have won against any immediate threat for socialized medicine is a period that involves very special dangers. I have alluded briefly to the external dangers—to the circumstances which will accustom Americans to accepting necessary government direction of the economy.

The word "necessary" is the important word in this connection. In this breathing spell the medical profession has won, we must not fail to demonstrate to all the American people that government direction of medicine is not necessary to a wise and adequate solution of the problem of paying for medical care.

The task before us is plain. We must prove in the months and years ahead that voluntary health insurance can succeed in America beyond any question of doubt.

If we do not succeed in this in the period we have won, we shall ultimately be

faced again with an overwhelming agitation for socialized medicine, an agitation so forceful that we may not be able to resist it.

As I have indicated, there are external forces that are bound to make medicine's task a hard one. As our people become more and more used to controls and to government direction, it will be increasingly difficult for them to recognize fundamental objections to a system of state medicine.

At this time, however, I am not so much concerned with the external forces that will make our task difficult. I am concerned rather with a much more pressing danger—the danger that inertia within our own profession will keep us from the resolute and positive sort of action that alone can win through to the continuing freedom of medicine.

In the months and years ahead—as in those of the recent past—every doctor will find himself under a heavy burden of work. He will be, necessarily, so busy caring for his patients and making up for the services of his colleagues in uniform that it will be difficult for him to keep in mind the broader, critical problems of our profession.

Another internal danger threatens. This is one with which we have been very familiar in the past. Nothing could be more natural than for the individual doctor in his own county society to feel that the challenge to make voluntary health insurance work is being met on the national and state level. It is easy for the over-worked practitioner to say to himself, "The American Medical Association is doing medicine's job here." Coming a step closer to home, it is equally easy for him to say, "The officers and councilors of my state association are giving this problem all the attention it requires."

The fact of the matter, however, is that the problem of providing adequate insurance arrangements for the medical care of the American people is a local problem, a grassroots problem, a community problem. It will not be solved satisfactorily unless every doctor and every local medical society in every community are consciously and deliberately dedicated to a positive program to extend voluntary health insurance to the point that it provides adequate protection for the overwhelming majority of the American people. The American people are going to have health insurance. If they do not

have it on an adequate voluntary basis, they will have it from the government. This is a fact with which every doctor must reckon. It is a fact toward which every doctor and every county society must feel a direct responsibility.

What, then, can the individual doctor and his county society do to make voluntary health insurance work? The first thing—and the thing that underlies all the rest—is to recognize with dead seriousness that so long as there are people in any community (except for the demonstrably indigent) who do not have an effective health insurance program, the political danger of socialized medicine continues to exist.

If every doctor and every county society could recognize and accept this simple proposition, our problem would be solved. What does such recognition mean in terms of specific action at the community level? It means, in the first place, that if there is not an adequate private or non-profit health insurance program available to the people of any community, it is the inescapable responsibility of the organized medical profession to see that such a program is established. It is the responsibility of the county society to see to it that organized medicine is represented on the corporate board of such a plan and that the profession is dedicated to making the plan work.

You in Kentucky have already done the job I have just referred to. You have established prepayment hospital and medical care plans in the direction of which the medical profession is properly represented. As I have studied the literature describing your plans, I have been convinced that you have the organizational machinery you need to do a first-rate job in giving protection to your people against the economic hazards of sickness.

The mere existence of an adequate plan, however, is not in itself sufficient. It remains the task of the medical profession to make the plan work.

Every doctor in every one of his contacts must be alert to the importance of selling the voluntary insurance plan. Every patient of every doctor must be aware of benefits participation in such a plan provides.

Beyond this personal communication with patients on the part of individual doctors, the county society and its woman's auxiliary have a responsibility to

carry forward public relations programs in the area through which the public at large will be thoroughly and constantly educated to understand the importance of prepaid medical care protection.

The experience of voluntary plans throughout the United States is now great enough to demonstrate what can be done through the medium of advertising, publicity, speeches and community relations efforts in general to achieve something close to a 100 per cent participation in prepaid medical care programs.

I do not propose to talk at any length about the public relations and advertising devices by which this community acceptance of voluntary health insurance may be achieved. Others, I am certain, are more competent than I to discuss such promotional techniques. As one who has been concerned, however, for many years with the practical problems of developing and administering a Blue Cross and Blue Shield program, I do wish to dwell on some particulars which seem to me to underlie an important part of the problem of good public relations for voluntary health insurance. These particulars involve common misunderstandings. I should like to treat them briefly one at a time.

The first set of misunderstandings involve the patient. Here it is important to see to it that the public understands the difference between an indemnity plan and a service plan. In too many instances, when the insurance program provides for payment direct to the hospital and physician, as I understand is the case in Kentucky, patients do not always understand that they are receiving the benefit. This whole matter is simply a question of proper understanding, and every doctor and every county society has a job of communication to do in achieving the understanding necessary.

Here are illustrations of other problems that grow out of lack of understanding on the part of patients:

1. In many instances the patient is not adequately aware of precisely what he has purchased when he buys a medical or hospital prepayment policy. Every sales agent should understand the importance of explaining clearly to every prospect all the elements of the policy—and, particularly, the exclusions—in words of one syllable. The patient should be informed that the day he signs his application is not his service date. Provisions of the

policy regarding "pre-existing conditions" should be explained in detail.

(In this connection, physicians also should understand the provisions of the policies held by their patients. It can be very embarrassing to a doctor to discover that his report as to the time when symptoms appeared can result in excluding his patient from benefits.)

2. The next thing necessary to obtain better patient response to voluntary health insurance is to correct and improve those portions of typical policies that cause misunderstanding. In voluntary prepayment plans sponsored by the medical profession, every effort should be made to do a good sociological job, to keep the fine print in policies to a minimum, to be lenient in interpreting questions relating to pre-existing conditions and to pay benefits in every case possible.

As actuarial experience increases, we may hope for a more or less uniform contract which will eliminate much present difficulty in interpretation by patients, physicians and hospitals alike. (It is particularly important that there be improved understanding on the part of hospitals and physicians as to just what constitutes hospital service and what constitutes medical service in the areas of laboratory, X-ray and anesthesia benefits. Here there is an important job of clarification to be undertaken jointly by the American Medical Association and the American Hospital Association.)

In connection with this matter of the simplification of policies as an aid to improved patient understanding, there is another irritating element in the fine print of too many policies. This relates to privileged communication. A troublesome problem arises for a doctor when he receives report forms from a variety of prepayment plans, some of which contain the statement that the patient, in applying for his policy, has waived the right of privileged communication. Report forms of other plans append a signed waiver or a photostat of the waiver. Many report forms make no mention of the matter.

This lack of uniformity in practice often makes it difficult for the physician to report candidly and may lead him to answer questions in a way he may later regret or have the effect of making him too cautious in his answer. For these reasons, all report forms should contain a definite statement in regard to the status of the waiver.

So far we have discussed the problem of obtaining better patient understanding of the benefits of voluntary health insurance. We have noted that doctors have a real responsibility in solving this problem. First by seeing to it that the patients who come to them understand precisely the contents of their insurance contracts, and, secondly, by using their influence as members of organized medicine to see to it that the contracts available constantly become better by elimination of much of the fine print, by holding exclusions to a minimum and by providing the uniform conditions to the greatest extent possible.

The whole problem, however, is bigger than the question of seeing that the patient understands his contract or working to improve and simplify such contracts. There is a great deal of progress that needs to be made in the understanding of the medical profession itself. An important part of the public relations job of any county society should be better to inform its members of their responsibilities for the success of voluntary health insurance. To a very large degree, the success of any plan depends on the cooperation of the individual doctors who provide service to subscribers of the plan.

Here, of course, the initially important thing is that a maximum number of doctors participate in the program. Next it is important that every doctor understand the sociological aspect of prepaid medical care. The benefits of voluntary health insurance, from a public relations point of view, can be largely dissipated if individual doctors do not exercise great judgment in seeing to it that subscribers to the plan receive protection against the high costs of illness commensurate with their need for such protection. In a medical care plan this means, in the case of many patients, a realistic setting of fees for service so that they will be substantially covered by benefit payments available under the plan.

Further, it should be the responsibility of every individual doctor and of every county medical society to see to it that physicians participating in the plan cooperate more perfectly in making their reports. It must be recognized that the success of any plan depends, in an important degree, on the efficiency and promptness with which claims are submitted and processed. Every doctor has an important responsibility to do his part

to make voluntary health insurance work with maximum efficiency.

As I looked over the literature relating to your Kentucky Physicians Mutual, I was enormously impressed with the file folder which is provided for every participating physician to give him in convenient form for easy reference the full details of his job in making the plan work. Such a folder, continuously kept up to date, should be a great aid to the doctor and his office assistants in complying with the requirements of the paper work of the plan.

Leaving now the individual doctor, I should like to emphasize that there is a special responsibility for those physicians who are officially chosen to be members of boards of trustees for prepayment plans. It goes without saying that every effort must be made to give the subscribers a constantly better and cheaper service. Management should strive for maximum economy consistent with a good sociological job. The percentage of the premium dollar devoted to costs other than the payments of benefits should always be under careful scrutiny.

Constant study and experimentation should be made in the direction of individual enrollment, catastrophic coverage and other goals that must be attained if voluntary health insurance is to provide the full and adequate protection required by the average family.

At the same time, doctors serving as directors of such plans should be among the leaders in advocating aggressive enrollment campaigns in the months ahead. Every economical device of promotion, publicity, advertising and persuasion should be exploited to the full.

In connection with every one of the points I have just been discussing, state and local groups will find valuable help in the recommendations and experience of the various national, state and regional organizations concerned with prepaid hos-

pital and medical care.

The county society should have a live-wire economics committee, as well as a good public relations committee. Together these committees should be abreast of all developments in the total national experience with prepaid medical care. Good liaison should be maintained with the state medical organization and prepayment plans. Full use should be made of the statistics of the Bureau of Economics of the AMA which has not in the past been sufficiently consulted.

In essence, then, the responsibility of the county medical society is a dual one. It is an economic responsibility to devise and support actuarially sound means for providing the people of the local community with thorough protection against the major costs of illness. Equally, it is the public relations job of winning public understanding and acceptance for the insurance program available.

If both the economic job and the public relations job are well done on the county level, we shall succeed in our objective to enroll 90 per cent of the American people in voluntary health insurance programs. The job must be done at the community level. In every community, the first responsibility must rest with organized medicine.

If this responsibility is effectively discharged during the period ahead of us—a period I have called “a breathing spell,” a period of challenge and of opportunity—we shall succeed in devising for the American people a system of security against the financial shock and anxiety of illness; we shall have found a typically American solution for a pressing problem; we shall have demonstrated that there is no need in America to borrow foreign systems of taxation and compulsion to get the job done. In short, we shall have proved that a free medical profession in the United States is equal, not only to the medical, but to the sociological and humanitarian problem that confronts us.

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JUDGE CURTIS, A LOYAL AND EFFICIENT COUNSEL, RESIGNS

Lee Roy Curtis, who began his services as the attorney for the Kentucky State Medical Association in 1922, resigned effective January 1, 1952. This became necessary when Mr. Curtis, on September 1, 1950, was persuaded to accept the appointment as a judge of the Jefferson County Circuit Court to which office he was elected for a six-year term in November, 1951.

In announcing to the Council Mr. Curtis' decision to accept this appointment, the Chairman of the Medico-Legal Committee, J. B. Lukins, M. D., wrote, "As a lawyer, his insight into the problems of the doctor has been almost uncanny. When trouble came, he was always fair to the layman, yet he could see the issue from the viewpoint of the physician. He recognized our frailties and limitations and was always patient and worked hard to be of real assistance."

A native of Woodford County and a graduate of the University of Michigan School of Law in 1903, Judge Curtis started in practice as an associate of the firm of Forch and Field in Louisville. Later he and Mr. Forch became partners. Following the latter's death, Judge Curtis practiced alone until he and his son, Norman, formed a partnership in 1940.

As in the medical profession where physicians will go to an outstanding colleague for advice on thorny problems, and often call other doctors in as consultants, Judge Curtis's advice was constantly sought by members of his own profession. Held in the highest esteem by the Bench and his fellow attorneys, he frequently tried cases before the jury for other attorneys, while he was in private practice.

Mr. Curtis is not only highly regarded by the medical and legal professions, but



Judge Curtis

his services were continually sought by companies of the insurance industry. He had specialized in liability or casualty law and was retained by many of the leading companies while he was in active practice.

In addition to a large practice, Mr. Curtis served as attorney and board member for the Christian Church Widows and Orphans Home, director of the Legal Aid Society, is a member of the Board of Directors of the Volunteers of America, a trustee and deacon of the Douglass Boulevard Christian Church and a member of

the Fall City Lodge of Masons.

Judge Curtis is a keen student of jury psychology. Some years ago, he was employed to represent a defendant in a small county seat town. Circumstances had operated to favor the plaintiff and feeling was running against the defendant.

Realizing he was facing a somewhat hostile jury that was critical of that "city feller," as the trial started Mr. Curtis knew the acute need for winning the jury's confidence. He saw a cuspidor on the far side of the courtroom not in use, so he walked over and in a casual way, with both hands on the not too clean vessel, carried it across the room in front of the jury and put it by his chair.

Sitting down, Mr. Curtis then went through his pockets as if looking for a chew of tobacco. Having seen a good farmer in the jury box bite off a chew a short time before, Mr. Curtis then got up and leaned across the rail and said to the juror, "Pard, could you give me a chew?" Showing both surprise and pleasure the twist of tobacco was produced.

The next day, the jurors filled Mr. Curtis's pockets with their prize twists of "long green." Incidentally the jurors gave a verdict for the defendant and invited Mr. Curtis back to try other cases.

Certainly the hundreds of physicians in Kentucky that Mr. Curtis has worked with and for, share the deep regret of the Medico-Legal Committee at losing him and believe with it, "We will miss him greatly."

THE EXECUTIVE COMMITTEE AND THE OFFICERS CONFERENCE

We think the Executive Committee of the Council should be congratulated upon the type of program presented at the County Society Officers Conference last month.

The Committee showed excellent judgment in choosing the subjects that were treated and was most fortunate in finding the uniformly high calibre of talent to handle these subjects.

A prominent guest of the Association at the Conference was heard to ask an officer of the Association at the close of the meeting, "How were you ever able to

get so many excellent people all on one program?"

The Legislative Panel, presented by our own associational officers, was a most worthwhile part of the proceedings. The Farm Bureau representative was outstanding, the talks on Blue Shield and rural health were superb and the public relations discussion most illuminating.

We join our President-Elect in urging our county officers to make the most of these profitable sessions in the years to come.

ORGANIZATION SECTION

Thyrotoxicosis Is Topic of April Telephone Seminar

"Management of Thyrotoxicosis" will be discussed on the April 22 Seminar broadcast over a statewide network by telephone and will be the last of the series of broadcasts this spring, Robert Lich, M. D., Louisville, Chairman of the Committee on Medical Education, announced.

Morris Flexner, M. D., Clinical Professor of Medicine at the Medical School, will moderate the session. R. Arnold Griswold, M. D., Professor of Surgery and Chairman of Department of Surgery, will discuss the subject from the surgical aspect; James R. Hendon, M. D., Assistant Clinical Professor of Medicine, endocrinology; and Gerald M. Peterson, M. D., Clinical Instructor in Radiology, the radiological approach.

Herbert L. Clay, M. D., Director of Postgraduate Refresher Training at the Medical School, arranged the program. The broadcast will originate in the General Hospital office of the Dean of the Medical School, Murray Kinsman, M. D.

The manuals, which will be used by the listening doctors of the subscribing counties, are being prepared and will be mailed about two weeks before the broadcast. Participants in the seminar are urged to scan their manuals before the broadcasts and submit questions to the Panel in time for the broadcast. These will be answered on the evening the seminar is presented.

First Rural Health Conference Set For May 7 And 8 In Louisville

The First Statewide Conference on Rural Health will be held May 7 and 8 at the Brown Hotel in Louisville, it has been announced by Walter L. O'Nan, M. D., Henderson, Chairman of the K.S.M.A. Committee on Rural Health.

Aubrey Gates, new Field Director of the A.M.A. Council on Rural Health, met with the new 16-man K.S.M.A. group on January 31, at which time the broad plans for the above conference were discussed and approved. The Council of the K. S. M. A. had also given the conference its blessing at the December 27 session.

The State Rural Health Council, which was

brought into being under sponsorship of the K.S.M.A. committee in 1951, through its Steering Committee at a meeting February 11 decided on the time, place and type of conference this would be. A program committee, appointed by Dr. O'Nan, has drafted the first plans for the Conference.

This first conference will be sponsored by the Kentucky State Medical Association and co-sponsored by the other member organizations of the Council, which are:

Cooperative Extension Work in Agriculture and Home Economics, State of Kentucky; Division of Child Welfare, Department of Economic Security, State of Kentucky; Division of Vocational Education, Department of Education, State of Kentucky; Kentucky Congress of Parents and Teachers; Kentucky Farm Bureau Federation; Kentucky Pharmaceutical Association; Kentucky State Association of Registered Nurses; Kentucky State Department of Health; Kentucky State Dental Association; and the University of Louisville School of Medicine.

The complete program for the May 7 and 8 conference will be published in the April issue of the Journal.

Scientific Exhibits Planned For Annual Session, Oct. 7-9

Members of the Association who wish to present scientific exhibits at the 1952 Annual Meeting, October 7, 8 and 9, should contact Everett L. Pirkey, M. D., Chairman of the Committee on Scientific Exhibits, 323 East Chestnut Street, Louisville, at an early date.

Plans for the scientific exhibits at the annual session this fall, which will be held at the Columbia Auditorium, Louisville, were laid at a meeting of the committee held February 28, Dr. Pirkey said.

While the scientific exhibits will not be as large, in 1952 as they were at the Centennial meeting, the committee expects this year's presentation to be one of the highlights of the convention.

Other members of the committee are D. Woolfolk Barrow, M. D., Lexington; Charles B. Wathen, M. D., Owensboro; and Harold Gordon, M. D., Charles F. Wood, M. D., and Jesshill Love, M. D., all of Louisville.



Above—J. E. Stanford, Executive Secretary, Kentucky Farm Bureau Federation; E. L. Henderson, M. D., Immediate Past President, A.M.A.; Louis H. Bauer, M. D., President-Elect, A.M.A.; Clark Bailey, M. D., President, K.S.M.A.; and, behind Dr. Bailey, Bruce Underwood, M. D., Secretary and General Manager, K.S.M.A.

Lower left—John T. T. Hundley, M. D., President of the Medical Society of Virginia, left, and R. Haynes Barr, M. D., K.S.M.A. President-Elect and Chairman of the Committee on Public Relations. Dr. Hundley discussed public relations during the morning session.

Lower right—Miss Charlotte Rickman, Rural Health Consultant for the Medical Society of the State of North Carolina; and Walter L. O'Nan, M. D., Henderson, Chairman of the Committee on Rural Health, left; listen to Clyde C. Sparks, M. D., Ashland, Chairman of the Council.

Officers Conference Praised By Guests And Members

The Second Annual County Society Officers Conference, held February 7, under the supervision of the Executive Committee of the Council, featured a day-long procession of outstanding talent.

The work of five guest speakers plus efforts of the State officers and committeemen that spoke, combined to make the session a most profitable one which received commendation from both visitors and members alike, officers of the Association said.

The session's final feature was the three-man legislative panel, consisting of Bruce Underwood, M. D., Secretary and General Manager; B. B. Baughman, M. D., Co-Chairman of the Legislative Committee; and the Association's attorney, Vincent Goodlet. This panel gave the officers a new insight into the problems faced in attempting to project a legislative program.

Louis H. Bauer, M. D., A.M.A. President-Elect, discussed briefly the functions of the A.M.A. and then urged the county medical societies and their officers to accept and discharge their responsibilities seriously.

J. E. Stanford, Executive Secretary of the 64,000 members of the Kentucky Farm Bureau Federation, described the view the Farm Bureau member takes of the doctor. Mixing his humor and his subject matter in a very effective manner, Mr. Stanford gave one of the most beneficial talks of the day.

John T. T. Hundley, M. D., President of the Medical Society of Virginia, gave a very impressive talk on "Finding the Sore Spots." Many officers said they would take an entirely new view of their "P-R responsibilities" home with them as a result of Dr. Hundley's speech.

Miss Charlotte Rickman, a full-time worker for the Rural Health Committee of the North Carolina State Medical Association, was enthusiastically received by the officers. Miss Rickman's presentation did much to point out the opportunities for service and leadership in health matters which the rural health movement offers the physician.

Carl F. Vohs, M. D., of St. Louis and nationally known authority on Blue Cross and Blue Shield, spoke on "The County Society's Relation to Blue Shield." Dr. Vohs' well-received talk appears in this issue.

Robert Lich, M. D., Chairman of the Committee on Medical Education, discussed briefly



Dr. Bauer, center, and Dr. Henderson, right, talk it over with Dr. Underwood prior to the Officers Conference Luncheon.

the plans for the Telephone Seminar, and Carlisle Morse, M. D., Chairman of the Committee on Diabetes, talked on the program of his committee.

Clark Bailey, M. D., President, presided at the morning session, R. Haynes Barr, M. D., President-Elect, at the afternoon session, and Clyde C. Sparks, M. D., Chairman of the Council, moderated the discussion periods. Due to inclement weather, attendance was not as good as expected. However, a total of 99 were registered, the same number as attended in 1951. A few were known to have entered without registering.

Galphin Succeeds Judge Curtis As Medico-Legal Counsel

J. B. Lukins, M. D., Louisville, Chairman of the Medico-Legal Committee, has announced T. M. Galphin, Attorney, Marion E. Taylor Building, Louisville, has been employed by the Committee as legal counsel for the Association to succeed Judge L. R. Curtis, Louisville, who has resigned.

Judge Curtis was elected in November as Judge of the Criminal Court in Jefferson County. He had represented the Association for the past thirty years.

Mr. Galphin was graduated from the University of Louisville School of Law in 1923 and got his Masters in Law from Columbia in 1924. Mr. Galphin has specialized in business and corporate law.

Chapter VIII, Section 6, of the K.S.M.A. By-Laws provide that the Medico-Legal Committee shall employ a general counsel and defend its "members in good standing against unjust suits for malpractice."

Five Guest Speakers Featured On April 30 KAGP Program

The program of the First Annual Scientific Assembly of the Kentucky Academy of General Practice has been completed and will be held in the Kentucky Hotel in Louisville, Wednesday, April 30, R. R. Slucher, M. D., Buechel, President has announced.

Five out-of-state guest speakers will be featured along with two local specialists, Dr. Slucher said. All K.S.M.A. members are invited to the session which will be held in the Terrace Room. Wives are invited to the luncheon session.

The complete program for the day-long session follows:

REGISTRATION 8:30 to 8:55 A. M.

MORNING SESSION 8:55 -11:45

R. R. Slucher, M. D., President, K.A.G.P., Presiding

"Prostatitis and Related Disorders"—

Robert Lich, M. D., Associate
Clinical Professor of Urology,
University of Louisville School
of Medicine

"Obstetrics (Pro. Persistent O. P.)"—

Joseph G. Crotty, M. D., Instructor
in Gynecology, College of Medicine
of University of Cincinnati, and
Director of Gynecology at Good
Samaritan Hospital

"Office Gynecology"—

Bernard Weinstein, M. D.
Associate Professor of Gynecology
at Tulane University School of
Medicine, New Orleans

LUNCHEON SESSION 12:00 - 2:30

R. R. Slucher, M. D., Presiding
(Wives Invited)

"Medicine in This Changing World"—

R. B. Robins, M. D., Camden, Arkansas
President, A.A.G.P.

"Caution, Curves Ahead"—

Mac. F. Cahal,
Kansas City, Missouri
Executive Secretary, A.A.G.P.

AFTERNOON SESSION 2:30 - 4:30

Keith P. Smith, M. D., Corbin
Vice-President, K.A.G.P., Presiding

"Pediatric Problems in General Practice"—

Alex J. Steigman, M. D., Professor
of Child Health, University of
Louisville School of Medicine

"Intestinal Obstruction"—

Phil Thorek, M. D.

Clinical Associate Professor of Surgery,
University of Illinois School of Medicine

The senior class of the University of Louisville School of Medicine will be the guests of the Academy for the entire day, D. G. Miller, Jr., M. D., Morgantown, Secretary of the Academy, who is assisting in arranging for the meeting, said.

Kentucky Ob. and Gyn. Soc. To Meet April 4 And 5

Robert Kimbrough, M. D., Philadelphia, will be one of the featured speakers at the Kentucky Obstetrical and Gynecological Society annual meeting at the Brown Hotel, April 4 and 5, Howard R. Molony, M. D., Covington, President of the Society, states.

Other speakers on the program will be A. B. Barrett, M. D., George G. Greene, M. D., Robert J. Griffin, M. D., and Albert E. M. Smith, M. D., all of Lexington, and Rudy F. Vogt, M. D., Louisville. Four papers will be given by the Resident Staff of the Ob-Gyn Department of Louisville General Hospital.

Round table discussions will be moderated by Silas H. Starr, M. D., and W. O. Johnson, M. D., both of Louisville. J. B. Marshall, M. D., Louisville, Secretary, is assisting in the arrangements.

Industrial Group To Meet At Pendennis Club March 24

The Second Louisville Area Industrial Health Conference will be held at the Pendennis Club, Louisville, at a dinner meeting March 24.

The conference theme will be improved health increases production, with emphasis on the small plant programs.

The featured speaker will be Robert B. O'Connor, M. D., Medical Director of Liberty Mutual Life Insurance Company, Boston, Massachusetts, who will discuss "Developing In-plant Health Services."

Other speakers will be Miss Agnes Anderson, Executive Secretary, American Nursing Association, New York, "Effective Industrial Nursing," and Joseph E. Flannigan, U. S. Public Health Service, whose subject will be "Industrial Hygiene at your Service." "In-plant Health Programs Pay Dividends" will be discussed by a speaker from industrial management.



Before addressing the University of Louisville Chapter of the Student A.M.A., Louis H. Bauer, M. D., A.M.A. President-Elect, inspected the Electrocardioscope at the General Hospital. Dr. Bauer also spoke at the County Officers Conference the same day. Reading from left to right: Officers of the U. of L. Chapter of Student A.M.A.—Martha Harmon, Secretary; William Ackerly, Vice-President; Charles McGaff, President; and Wanless Mann, Treasurer; Dr. Bauer; Herbert L. Clay, M. D., Associate Professor of Medicine, U. of L. School of Medicine; and Faculty Advisers at the Medical School, Richard C. Taylor, M. D., and James C. Drye, M. D.

More Than 300 Hear Dr. Bauer At U. Of L. Student A.M.A. Meet

More than 300 members of the University of Louisville Chapter of the Student A.M.A., faculty members and interns and residents crowded into the amphitheatre of the Louisville General Hospital to hear Louis H. Bauer, M. D., Hempstead, New York, on February 7.

The meeting, according to Charles McGaff, President, was sponsored by the local chapter of the Student A.M.A.

Officers of the local chapter were guests of the Kentucky State Medical Association at the luncheon of the County Society Officers Conference at which Dr. Bauer was guest speaker.

Dr. Bauer discussed the functions of the various agencies, councils and committees of the American Medical Association in an address described as very profitable by Mr. McGaff. Following the talk, a question and answer period was held.

The guest speaker, a cardiologist, toured the hospital for an hour before his talk and was accompanied by officers of the local chapter and members of the advisory committee.

Dr. Horine Writes Introduction

Emmet Field Horine, Brooks, the official historian of our Association, wrote the introduction of a new book entitled "An Inaugural Discourse On Medical Education" by Daniel Drake.

This new volume, released by the publishers in late January, is described in the book review section.

Dr. Horine, an eminent authority on Dr. Drake, writes an interesting and informative introduction.

Drs. Hall, Keeton And Moore Added To Editorial Board

The Editorial Advisory Committee announces the appointment of three new men to the Board of Consultants on Scientific Articles.

James M. Keeton, M. D., Ashland, a surgeon, has been named to take the place of Richard Rust, M. D., Newport, who was appointed to serve on the Editorial Advisory Committee.

Two new internists have been added to the Board. They are: William P. Hall, M. D., Pa-

ducah, and Frank H. Moore, M. D., Bowling Green.

Other members of the Editorial Advisory Committee are Guy Aud, M. D., Louisville, Chairman, and James E. Hix, M. D., Owensboro.

Scholarship To Commemorate Dr. Hal E. Houston

As a tribute to Dr. Hal E. Houston, Surgeon and Secretary-Treasurer of the Houston-McDevitt Clinic of Murray, his family and citizens of Calloway County have donated to the Rural Kentucky Medical Scholarship Fund the remaining \$672.00 of a \$2,000 scholarship. The scholarship will be named The Hal E. Houston Memorial Scholarship and is to be used to further the medical education of a Calloway County boy or girl.

Dr. Houston's tragic death on January 14 resulted from burns received several days earlier when the family's home caught fire while the family was sleeping. The fire also took the life of Mrs. Houston. Their three children escaped without injury.

The donation complements \$1,328 raised toward a scholarship by the Calloway County Farm Bureau during the original campaign sponsored by the Kentucky State Medical Association and the University of Louisville School of Medicine for the Rural Kentucky Medical Scholarship Fund. At that time the Houston family contributed \$2,000 identified as The Houston Memorial Scholarship.

Pediatricians To Meet April 18 At Pendennis Club

The Kentucky Society for the Advancement of Pediatrics is preparing for its third annual meeting to be held Friday, April 18, at 4 p. m., at the Pendennis Club.

The program which has not yet been announced will be of the same high calibre as the two preceding ones.

Membership in the Society is open to any graduate of a grade A medical school in good professional standing engaged in Pediatric practice or especially interested in Pediatrics.

A cordial invitation is extended to the physicians of Kentucky who are interested in children to become members of the Society. For further information write to: Doctor Leonard T. Davidson, President, Children's Hospital, Louisville 2, Kentucky.

Dr. Clay Speaks At First District Meeting In Murray

"Recent Advances in Electrocardiography" was discussed by Herbert L. Clay, M. D., Associate Professor of Medicine at the University of Louisville School of Medicine, at the first meeting of the year of the First Councilor District, which met February 14, in the Science Building of the Murray State College, J. Vernon Pace, M. D., Paducah, Councilor, has announced.

Dr. Ralph Wood, President of the College, talked on "Nursing Education and Pre-professional Training at Murray." The dinner was served by the Department of Home Economics of the College.

The Calloway County Medical Society, of which James Hart, M. D., Murray, is President, was the host society, and Hugh L. Houston, M. D., Murray, made the arrangements for the program.

New Members of K.S.M.A.

The Association welcomes the following new members:

Bracken—J. G. Carter, Augusta.

Campbell—L. E. Oliver, Carrollton.

Casey—Cathryn C. Vaden, Liberty.

Laurel—E. C. Seeley, London; C. A. Walde-mayer, London.

Montgomery—Wreno Hall, Mt. Sterling.

Perry—Lloyd A. Owens, Hazard; Harold L. Dahl, Hyden.

Fayette—William T. Swartz, Lexington.

Grant—O. A. Cull, Corinth; Smith H. Gibson, Williamstown.

McLean—P. J. Malagrine, Sacramento.

Muhlenberg—Frank Bechtel, Greenville.

Campbell-Kenton Society To Have Emergency Call Bureau

The Campbell-Kenton Medical Society has established an emergency call bureau, Arthur F. Schultz, M. D., Newport, President, has announced.

The northern Kentucky physicians have entered into an agreement with the Cincinnati Academy of Medicine which has operated a bureau for some time, Dr. Schultz said, to provide emergency service for their patients.

Any patient of a member of the Campbell-Kenton Society who cannot locate his personal

physician, may call the well advertised number and receive medical attention at once.

The House of Delegates of both the Kentucky State Medical Association and the American Medical Association have gone on record as encouraging the establishment of these bureaus.

"OB." Congress To Convene March 30

The Fifth American Congress on Obstetrics and Gynecology will be held at the Netherland Plaza in Cincinnati March 31 through April 4. Howard Molony, M. D., Covington, President of the Kentucky Obstetrical and Gynecological Society, announced.

It will be attended by the members of the 28 different professional and lay organizations that make up the American Committee on Maternal Welfare, Dr. Molony said.

Among the objectives of the meeting is the promotion of a better understanding and a greater degree of cooperation between the medical profession and private and public agencies looking toward the improvement of the welfare of the mother and her offspring.

RX for Doctor-Patient Relations

1. The doctor must be made to feel right about charging the patient a fee.
2. The patient must learn more about the doctor's moral right to charge a fee.
3. The doctor should set his fee on a valid, business-like basis—and the patient must be informed that this is so.
4. The doctor should establish his own fee schedule, avoiding scaled-up fees based on ability to pay.
5. The patient must be taught that the money he pays his physician is a desirable "investment."
6. The patient must learn why medical care today costs more.
7. The doctor should permit the patient to become an active and informed participant in his own treatment, rather than be only a passive recipient.
8. The patient's desire to be appreciated and liked by his doctor should be satisfied.

9. The patient's wish for continuity in his relationship with his doctor should be fulfilled.
10. The public's feeling of being kept at a distance by the medical profession must be removed.

(From the "Public Relations Reporter" of the Pennsylvania State Medical Society, October 26, 1951)

Dr. Rowntree To Head AMA Group Studying Industrial Health

Gradie R. Rowntree, M. D., Louisville, was elected Chairman of a new American Medical Association committee activated at the Twelfth Annual Congress on Industrial Health, sponsored by the A.M.A. in Pittsburgh January 18-19, 1952.

This committee, which is made up of state industrial health committee chairmen, hopes, Dr. Rowntree said, to form an active link between the A.M.A. Council and state medical societies in matters pertaining to the health of the industrial worker.

Dr. Rowntree is Chairman of the K.S.M.A. Committee on Industrial Health and is Professor of Community Health of the University of Louisville School of Medicine.

Hill-Burton Funds Helping Build 23 Kentucky Hospitals

According to Joseph S. Lawrence, M. D., Director of the A.M.A. Washington office, the status of Hill-Burton Hospital Construction Program in Kentucky as of January 1, 1952 is as follows:

UNDER CONSTRUCTION: 23 projects at a total cost of \$12,226,811, including federal contribution of \$7,535,287 and designed to supply 1228 additional beds.

APPROVED, BUT NOT YET UNDER CONSTRUCTION: 8 projects at a total cost of \$4,503,284, including \$2,988,857 federal contribution and designed to supply 462 additional beds.

COMPLETED AND IN OPERATION: 23 projects at a total cost of \$12,689,893, including federal contribution of \$4,852,625 and supplying 905 additional beds.

President's Page

Within the next few months the question of Compulsory Health Insurance and President Truman's recently appointed Commission to study the health needs of the nation will be the subject of much discussion. Because of its importance to the medical profession and its political significance, I am submitting in part a special message by Dr. John W. Cline, President of the American Medical Association, which appeared in the January 19, 1952, issue of *The Journal of the American Medical Association*. It is my hope that you will familiarize yourself with the questions involved.

"Establishment of the President's Commission on the Health Needs of the Nation is the latest maneuver in President Truman's campaign to socialize the medical profession. This commission, to be financed from emergency funds allocated for national defense, is a transparent fraud on the American people. Every physician and all others associated with us in caring for the health of the nation should clearly understand its absurdities and its dangerous political significance.

"The President's statement announcing formation of the commission to 'make a critical study of our total health requirements, both immediate and long-term, and (to) recommend courses of action to meet these needs,' was dated Dec. 29, 1951. Immediately, Dr. Gunnar Gundersen and I issued statements to the press voicing strong opposition to the proposal and exposing its political purpose.

"Both President Truman and Dr. Paul B. Magnuson, chairman of the commission, have insisted publicly that it is an unbiased, impartial group. The degree of impartiality which may be expected from this commission is indicated by the following statement of its chairman, Dr. Magnuson, as reported in the January 14 issue of the *Time* magazine: 'If the A.M.A. hierarchy devoted as much time to care of their patients as they do to political maneuvering, we'd all be better off.' If this type of 'impartiality' pervades the atmosphere in which the commission meets

and works during the months ahead, it is clearly apparent that this new commission will become just another adjunct of the Truman-Ewing propaganda machine.

"This proposed survey, to be completed within a year or less, is to cover research of monumental proportions, if the President's outline of objectives is to be followed, research that could not possibly be accomplished with either accuracy or adequacy within less than three to five years.

"Since the study of the health needs of the nation is a continuing one and is participated in by the medical profession and by other private agencies and groups, much duplication of effort by the President's Commission is inevitable. The Brookings Institution's two to three year study of the availability of medical service in the United States, covering many of the subjects mentioned in the President's directive to the Commission, which is still under way and which will be completed this year, a new study on the financing of hospital care being undertaken by the Commission on Financing of Hospital Care, the studies of the Council on Industrial Health, Council on Medical Service, and Committee on Federal Medical Service of the American Medical Association, and the continuing studies of 53 constituent medical societies, 2,000 component county societies, and innumerable other voluntary and local governmental agencies are providing infinitely more information than this new commission will ever be able to develop.

"It is unfortunate that the President refuses to admit the great progress that has been made by the medical profession in improving the health of the nation; he appears wholly uninformed concerning the reports that already have been made on medical progress of the past ten years, and most particularly of the past three. The entire fabric of the administration's case for federal control of the medical profession is woven from obsolete material and inaccurate figures. The people are being asked to believe in an emergency

(Continued on Page 136)

County Society Reports

BELL

The regular meeting of the Bell County Medical Society was held February 8, 1952, at the Bell County Health Department in Pineville.

In the absence of the President, the Vice-President called the meeting to order. Members present were: Dr. Ed Wilson, Jr., Dr. Ed Wilson, Sr., Dr. J. S. Parrott, Dr. Fred Weller, Dr. Percy Zanger, Dr. Ralph Alford, Dr. James Golden and Dr. C. S. Scott.

Dr. Fred Weller presented a case of Multiple Myeloma and gave a review of the literature.

It was unanimously voted that Mr. Raymond Jones be notified that we subscribe to the current "Telephone Lecture Series." It was also agreed that the meeting be held at the Kentucky Utilities Building in Pineville and that this meeting was to be substituted for the regular monthly meetings. Dr. James Golden was appointed to obtain authorization for the use of the building and to arrange with the Telephone Company for the hook-up of the speaker. It was unanimously voted that the Society pay the subscribed rate of fifty cents per member for the February lecture.

The minutes of the last meeting were read and approved.

The meeting adjourned.

C. S. Scott, M. D., Secretary-Treasurer

JEFFERSON

The December meeting of the Jefferson County Medical Society was held Monday evening, December 17, 1951, at the Seelbach Hotel.

Thirty-eight members were present for dinner, and about ten additional for the meeting.

The meeting was called to order by the President, Dr. Lytle Atherton. The minutes of the previous meeting were read and approved.

The following new members were elected: Oren A. Beatty, M. D., and James M. Wygal, M. D., to Active Membership.

The application of Dr. O. R. Reeser for transfer to Emeritus Membership was approved.

The Secretary read a communication from Dr. James Robert Hendon to Dr. R. R. Slucher recommending that other county societies be invited to attend the February meeting at which Dr. Willard O. Thompson is to speak on "Uses and Misuses of Sex Hormones." He also recommended that Dr. Thompson's traveling expenses be paid by the Society. The President

turned this letter over to the Executive Committee for action, to report to Dr. Slucher.

The Secretary read a letter from the K.S.M.A. to county medical societies announcing a telephone refresher course for doctors, prepared by the Committee on Medical Education, headed by Dr. Lich. Programs will be given February 26, March 18 and April 22 at 7:30 P. M. and the Jefferson County Medical Society is urged to subscribe to the course.

An announcement was read of a medical office building to be erected at Taylorsville Road and Wallace Avenue; interested persons are to phone Mr. Lewis R. Long.

The Secretary read a request that the Society help buy tickets for underprivileged children to the Shrine Circus February 11-17.

The Secretary read a letter to county medical societies from the American College of Surgeons inviting members to attend a sectional meeting of the College to be held in Birmingham, Alabama, January 10, 11, 12.

There was a discussion by Dr. Shiflett, Dr. Hurst and Dr. Alfred Miller. Dr. Hurst made a motion that the matter be referred to a committee to investigate and make a complete report at the next meeting. This was seconded and carried. Dr. Atherton stated it would be referred to the Program Committee for investigation.

SCIENTIFIC PROGRAM

Due to the illness of Dr. Wallace Frank, scheduled speaker, the program was changed to voluntary case reports. A case report of commissurotomy in mitral stenosis was given by Dr. Armand T. Gordon, and a case report on tracheotomy by Dr. Joseph C. Ray.

The meeting adjourned at 8:30 P. M.

Austin Bloch, M. D., Secretary

LETCHER

By previous arrangement the January Medical and Dental meeting of our Society was postponed to February 5, 1952, at which time said local meeting was held in the offices of Drs. Carl and Owen Pigman and Dr. B. C. Bach.

The meeting was called to order by the Vice-President, Dr. Lee Moore, in the absence of the President, Dr. Lundy Adams. Members present were: Drs. Lee Moore, Owen Pigman, Carl Pigman, B. C. Bach and R. Dow Collins—a sufficient number for a quorum.

The Secretary presented reports and letters

which he had received as County Society Secretary and a discussion followed. One such letter that seemed very worthy was from the State Office asking us to consider the (1) Hospital Bill; (2) The Medical Practice Act, and (3) The Professional Titles Act. On due motion and unanimous passage, a resolution was made asking that the Secretary write Senator Archie Craft, and Representative Bill Adams, Frankfort, and let them know that such a resolution was adopted, and ask for their support of these measures at the present session of the General Assembly.

Also, the "Telephone Seminar" which was rejected last meeting time, was again brought up, and it seemed that after more thought that a majority wished to have said "Telephone Seminar."

R. Dow Collins, M. D., Secretary

McCRACKEN

The November meeting of the McCracken County Medical Society was held Wednesday, November 28, 1951, at the Ritz Hotel with Dr. W. P. Hall presiding. There were 18 members and six guests present.

SCIENTIFIC PROGRAM:

Symposium of Acute Pancreatitis.

1. "Medical Aspects." Dr. Pittman Orr
2. "Surgical Aspects." Dr. Walker Turner
3. "Opening Discussion." Dr. John Quertermous
4. "Further Discussion." Dr. D. C. Haugh

The minutes of the last meeting were read and approved.

A motion was made by Dr. Eugene Blake and seconded by Dr. Sargent that the society subscribe to the telephone program.

Dr. Logan Weaver invited the society to have these programs at the McCracken County Health Clinic.

A motion was made by Dr. Turner and seconded by Dr. Purdy that amplifier committees see to details on this program.

A motion was made by Dr. Billington and seconded by Dr. Weaver that the secretary be instructed to write a letter to Miss Hughes requesting Dr. Bippert to return books to library at Riverside. Chairman of the library committee is to look into the situation and see if a letter should be written to each member on returning books.

A motion was made by Dr. Sargent and seconded by Dr. Hunt that the society have \$2.50 steak dinners served at the next meeting.

The meeting was adjourned at 9:30 P. M.

George H. Widener, M. D., Secretary

McCRACKEN

The December meeting of the McCracken County Medical Society was held at the Ritz Hotel on Wednesday, December 26, 1951, with Dr. W. P. Hall presiding. There were 21 members and 1 guest present.

Minutes were read and approved.

A motion was made by Dr. Robertson and seconded by Dr. Billington to give vote of confidence to chairman of amplifier committee.

A motion was made by Dr. Goodlow Sargent and seconded by Dr. Vernon Pace that the eggnog bill of \$9.10 be paid to hotel. The motion was passed.

A motion was made by Dr. Eugene Blake, and seconded by Dr. James Ward that the Society pass a resolution and send a copy to Lawrence Wetherby, Governor, Strother Melton, Senator, Charles Burnley, Representative, and Fred Morgan, Representative, that they make every effort to help passage of Hospital Licensure Act. The motion was passed.

Treasurer's Report: \$847.09 plus a \$75.00 bond that is now mature.

Election of Officers:

President, Dr. Eugene Blake; Vice President, Dr. Eugene Sloane; Secretary-Treasurer, Dr. George H. Widener; Delegates, Dr. Robert Reeves, 52; Attending, Dr. Billington, 52; Delegates, Dr. Abell 52-53; Board of Censors, Dr. E. Pace, 52-53; Dr. Bob Overby 52; Dr. Jas. Ward, 52-53-54; Library Committee, Dr. Vernon Pace, Dr. Jas. Ward, Dr. Eugene Sloane; Program, Dr. Billington, Dr. Robertson, Dr. C. W. Raymond.

A motion was made by Dr. Turner and seconded by Dr. Vernon Pace that resolution be adopted to express thanks to Dr. Jackson for his 17 years as treasurer to society.

Dr. James Ward moved that a candidate for membership be made to present a paper before society. Amended by Dr. Sloane to read that the policy and precedent be set to invite the candidate to present a paper. Seconded by Dr. Billington.

A motion was made by Dr. Blake and seconded by Dr. Cunningham and passed to increase meals to \$2.50.

George H. Widener, Secretary

MUHLENBERG

The regular meeting of the Muhlenberg County Medical Society was held January 18, 1952. Members present were Drs. G. F. Brockman, R. E. Davis, J. P. Walton, Claude and Foster Wilson, H. H. Woodson, G. H. Rodman, and G. L. Simpson.

The meeting was called to order by the President, Dr. Claude Wilson.

The minutes of the preceding meeting were read and approved.

Communications—The Secretary read a report of Negotiations between the Kentucky State Medical Society and the Kentucky General Society with accompanying transmittal from the KSMA requesting that the Society extend associate membership to the dentists. On motion of Dr. G. L. Simpson, properly seconded and carried, the Secretary was instructed to invite dentists of the county to the next meeting to explore their desires in this matter.

The Secretary was authorized to take care of a present for the laboratory technician.

The Secretary read a letter from the council of the Kentucky State Medical Association requesting support for the legislative matters pending before the Kentucky State Legislature.

New Business—The Society discussed, at some length, current attitudes toward various types of cultist practitioners, and explored the bounds of ethical conduct with reference to them. No motion was adopted.

On motion, the meeting was adjourned.

G. F. Brockman, M. D., Secretary

SCOTT

The Scott County Medical Society held its regular monthly meeting at the John Graves Ford Memorial Hospital at 12 o'clock noon on Thursday, February 7, 1952. The following members were present: Drs. D. E. Clark, Jr., L. F. Heath, W. S. Allphin, H. G. Wells, A. F. Smith, F. W. Wilt, E. C. Barlow, P. H. Crutchfield and H. V. Johnson. Mr. Joe Kelly, Hospital Administrator, was present also.

Mr. Kelly recommended that all patients except Ob and Emergency cases be given routine lab. examination.

Not having a scientific program the meeting adjourned to meet on the first Thursday in March.

H. V. Johnson, Secretary

SHELBY-OLDHAM

The regular monthly meeting of the Shelby-Oldham Medical Society was held at the Stone Inn on January 24th. Dr. L. B. Sternberg was the host.

The following members and guest were present, Drs. Alexander, L. B. Sternberg, H. H. Richeson, S. B. May, E. G. Houchin, B. F. Shields, B. B. Sleadd, H. B. Mack, J. T. Walsh,

M. D. Klein, A. C. Weakley, W. H. Nash, George Perrine, R. M. Whitaker and C. C. Risk.

After the dinner the meeting was called to order by the president, Dr. Alexander.

The Secretary announced the February meeting would be at the Shelbyville Christian Church. This being the Telephone Program meeting, better arrangements could be made in Shelbyville. The March and April meetings will be at the Church also.

The Secretary read a letter from Dr. John S. Sprague of the Fayette County Medical Society in regard to a Bill before the Kentucky General Assembly to quarantine communicable cases of tuberculosis. No action was taken.

At this time the meeting was turned over to the host, Dr. Sternberg, and he introduced Dr. John J. Wolfe, of Louisville. Dr. Wolfe gave a very interesting talk on "Traumatic Wounds."

Meeting adjourned at 9:45 P. M.

C. C. Risk, Secretary

SIMPSON

The joint meeting of the County Medical Society and Board of Health at the Community Hospital was called to order by President Moore with the following members of the Society present: Doctors Witt, Lamb, Moore, Beasley, Wilson, Bralliar, and Orsburn. The three former being members of the Board of Health.

There was no planned program. However, several health activities were discussed at the request of Dr. Roy Orsburn, health officer. The purpose of this was that there be a clear understanding of the relationship between the medical fraternity and the health department in the performance of its duties. The following items were taken up for consideration and action:

First: Each physician to have the privilege of establishing and releasing his patients from quarantine.

Second: Immunizations may be given with the consent of the parents.

Third: May admit indigent Venereal Disease cases to service.

Fourth: Render services to Tuberculosis patients and report laboratory findings to the family physician.

Fifth: May visit the infant and preschool age group and hold Well Child Health conferences.

Sixth: Examinations of pupils may be made

by either the family physician or the Health Officer.

Seventh: See if prenatals are visiting their family physician. Encourage them to do so regularly.

Eighth: Food handler's examination be compulsory. The applicant may choose his or her examiner. Teachers, bus drivers, and janitors also to have the privilege to be examined by their family physician.

Ninth: Render services to crippled children.

Tenth: The health department may collect specimens of water, milk, blood specimens, sputums, and swabs of the gums and throat for examination.

Eleventh: Sanitation activities approved.

After these discussions were closed the meeting was converted into a social hour. Refreshments were served by Doctor Moore and Mrs. Moore.

Carter Moore,
President, Medical Society
W. C. Witt,
Chairman, Board of Health

UNION

The regular meeting of the Union County Medico-Dental Society met at 7:30 P. M. on January 15th.

The meeting was called to order by William Humphrey, M. D., President.

Minutes of the last meeting were read and approved.

Dr. Humphrey introduced Emil Kotcher, M. D., as guest speaker. The Doctor is the state epidemiologist. Dr. Kotcher spoke on some of the problems concerning epidemiology. He stressed the importance of accurate information concerning morbidity, such as cases of Vivax Malaria and other types, and the extreme importance of a correct diagnosis on this and on all communicable diseases. He also stated that Winter Diarrhea and Infectious Hepatitis are two diseases that are giving a bit of trouble. The cause of the diarrhea is not known, however it is a self limiting infection, there is no specific treatment.

Dr. Kotcher stressed the importance of reporting all communicable diseases to the health officer.

A very interesting round table discussion with questions and answers was well pleasing and educational, the evening was a very instructive and enjoyable one. Dr. Kotcher we hope can be with us again in the future.

Members present were: Drs. Carr, Conway,

Stewart, Atherton, Humphrey, Graves, Purver, Higginson.

A. W. Andreasen, Secretary-Treasurer

WARREN-EDMONSON-BUTLER

The Warren-Edmonson-Butler County Medical Society met on January 8, 1952, at the Helm Hotel in Bowling Green. A resolution favoring the passage of a bill by the Kentucky General Assembly was passed—in principle that communicable cases of tuberculosis should be quarantined. The Society also has decided to offer a scholarship to a deserving girl each year for nurses training.

Dr. James R. Freedman and Dr. Richard F. Grise were introduced as new members of the Society. Dr. H. W. Gingles, a retired physician residing in Warren County, was made an honorary member. A most interesting scientific program with movies and lantern slides was presented by Dr. Robert Lich of Louisville concerning Urology in General Practice. About twenty members were present.

Frank H. Moore, M. D., Secretary

PRESIDENT'S PAGE

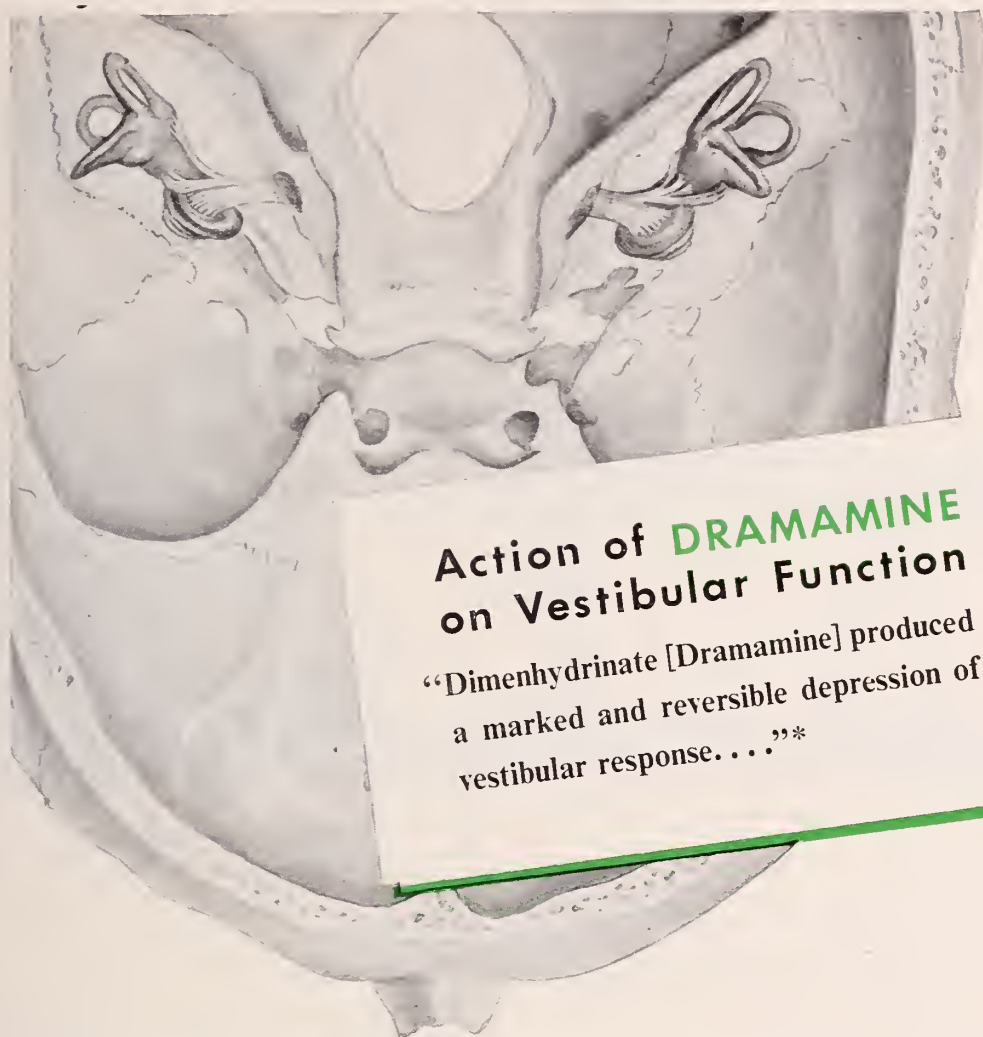
(Continued from p. 132)

that did not exist even a decade ago and certainly does not exist today. That they are not too impressed is evidenced by the fact that, during the three years of Mr. Truman's most ardent advocacy of compulsory health insurance, more than 25 million additional persons enrolled in the many fine voluntary health insurance plans now available in the United States. Best estimates indicate that at this time over 80 million persons in this country have voluntarily obtained insurance as a cushion against the major costs of illness and the American people are determined to resolve this problem without either government help or interference.

"It seems almost incredible that, in the face of all these facts, emergency defense funds should be allocated to a gigantic health survey that cannot possibly achieve its aims in the time allotted, is not necessary, and is so palpably political in its design."

Clark Bailey

PRESIDENT



Action of **DRAMAMINE** on Vestibular Function

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In a study of the action of Dramamine on vestibular function, Gutner and his associates found that Dramamine "significantly delayed the onset of nystagmus, shortened the duration of nystagmus and increased the milli-ampere necessary to effect tilting."

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Average dose — 50 mg.



*Gutner, L. B.; Gould, W. J., and Batterman, R. D.: Action of Dimenhydrinate (Dramamine) and Other Drugs on Vestibular Function, Arch. Otolaryng. 53:308 (March) 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

News Items

William H. Sewell, M. D., Fulton, graduate of the University of Louisville School of Medicine, class of 1945, is now in the armed forces and is stationed at the Army Hospital, Aberdeen Proving Grounds, Maryland.

Peter J. Trinca, M. D., who has been practicing in Fulton where he operated the Haws Memorial Hospital for the past several years, has moved to Iona, Michigan.

Charles E. Hall, M. D., 1948 graduate of the University of Louisville School of Medicine, is now located with the Harlan Hospital, Harlan, Kentucky.

Irvin S. Miller, M. D., graduate of Columbia University College of Physicians and Surgeons, class of 1926, now has his office with **Dana Snyder, M. D.**, of Hazard. He has been recently practicing in Clintwood, California.

Marvin R. Batchelor, M. D., a 1950 graduate of the University of Tennessee College of Medicine, is practicing in Virgie, Pike County. Since graduation Dr. Batchelor has been with the Knoxville General Hospital and Clinch Valley Hospital, Richlands, Virginia.

Henry J. Beilman, Jr. M. D., who has located at 4556 Preston Highway, Louisville, and will do general practice, is a graduate of the University of Louisville School of Medicine, class of 1949. He has been in Scranton, Pennsylvania, since graduation.

Robert A. Matuska, M. D., has located in Martin, Floyd County. Dr. Matuska, who is a 1948 graduate of the University of Cincinnati College of Medicine, served his internship in Good Samaritan Hospital, Cincinnati, and was in the United States Air Force for about two years.

Anthony R. Giglia, Jr., M. D., has located at 59 St. Joseph Lane, Park Hills, Newport, for the practice of Obstetrics and Gynecology. He is a graduate of the University of Maryland School of Medicine, class of 1943.

Kenneth Chapman, M. D., former assistant chief of the division of hospitals of the United States Public Health Service in Washington, has succeeded Victor Vogel, M. D., as medical officer in charge of the U.S.P.H.S. Hospital in Lexington. Dr. Vogel has transferred to Paris, France, as medical director of U.S.P.H.S. in Europe and the British Isles.

Harry Starr, M. D., is now associated with **H. Lester Reed, M. D.**, 315 Fincastle Building. He will limit his practice to neurosurgery. Dr. Starr comes from Philadelphia, Pennsylvania.

Keith Crume, M. D., Bardstown, has announced the forming of a partnership with **H. M. Millen, M. D.**, who has recently returned to Bardstown from Lawrenceburg, Tennessee, where he has practiced for the past two years.

Bert E. Moore, M. D., a graduate of the University of Louisville School of Medicine, who was formerly connected with the Tuberculosis Hospital, Madisonville, is now located in Mauston, Wisconsin.

Thomson R. Bryant, Jr., M. D., has opened his office at 200 West Second Street in Lexington. He graduated from the Harvard Medical School in 1943 and took his internship and residency at New York Presbyterian Hospital, New York City.

Maurice Kaufman, M. D., Lexington, announces the association of **Lloyd Dewald Mayer, M. D.**, in the practice of Allergy. Dr. Mayer is a graduate of the University of Louisville class of 1944. He has recently completed his requirements for certification in allergy and internal medicine.

Russell Teague, M. D., who has a broad acquaintanceship in Kentucky and who is now Commissioner of Health in Pennsylvania, living at Harrisburg, recently participated in a meeting of the National Health Council in New York City.

Lawrence M. Quill, M. D., Newport, was elected to the Southern Surgical Association. (Oldest Surgical Association in the nation). Dr. Quill is the first northern Kentuckian chosen by the organization, which is composed of Surgeons of the southern states.

Alice N. Pickett, M. D., has retired after 38 years of activity as a Louisville physician. Dr. Pickett is a widely known obstetrician and professor emeritus of obstetrics at the University of Louisville.

Friends of the late **William Kenney, M. D.**, Paris, are planning to furnish a room at the new Bourbon County Hospital in tribute to his memory. Those who wish to have a part in this memorial are requested to mail their gifts to Mrs. W. B. Ardery, Paris, Route 5.



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In Memoriam

WILLIAM KENNEY, M. D.

Paris

1877 - 1951

Dr. William Kenney died suddenly December 27, 1951. He was a graduate from the Kentucky School of Medicine, Louisville, in 1898. He was too young at that time to receive his diploma with the privilege of practicing his profession, but was granted a special license when a typhoid fever epidemic became prevalent in Paris. Dr. Kenney performed what is believed to have been the first appendectomy in Bourbon County. In 1915, he took a post-graduate course in Chicago, in Ear, Eye, Nose and Throat. He served terms in the Paris City Council, and was Mayor pro-tem for a short time. For the past 20 years, Dr. Kenney had managed Glen Kenney, his thoroughbred horse farm.

BURT A. MOORE, M. D.

Shepherdsville

1878 - 1952

Dr. Burt A. Moore, Shepherdsville, died January 29, 1952 in Louisville. A graduate of the University of Louisville Medical Department in 1907, he practiced for several years in Kansas and Louisville, before returning to Shepherdsville. He was retired at the time of his death.

BOOK REVIEWS

AN INAUGURAL DISCOURSE ON MEDICAL EDUCATION by Daniel Drake, M. D., with an introduction by Emmet Field Horine, M. D., will be published in a limited Edition of 500 copies at \$5.00 per copy by Henry Schuman, Inc., 20 E. 70 St., New York 21, N. Y., on January 18, 1952.

The Discourse was originally delivered at the opening of the Medical College of Ohio in Cincinnati on November 11, 1820 and has now been reprinted for the first time and made available to the general public at a nominal price. The volume has been beautifully designed by High Acres Press, Coral Ridge, Kentucky, and printed on pale green, deckle-edge, antique paper. The title page immediately preceding the Discourse is a facsimile of the original title page of the 1820 Edition.

Dr. Emmet Field Horine, whose introduc-

tion outlines Daniel Drake's career and contributions to medical science and education, is an authority on this great American Doctor. He, himself, now occupies a position at the University of Louisville, School of Medicine, similar to that held by Dr. Daniel Drake a hundred years ago. He is the author of many essays about medicine and medical practice in the early days of Kentucky. He edited an autobiography of Daniel Drake, entitled **PIONEER LIFE IN KENTUCKY** and a volume of Drake's letters on Slavery, both published by Henry Schuman, Inc.

This unique volume will be of special interest to libraries and medical men, students as well as collectors of Americana. Drake's writings rarely appear for sale and no copy of his Inaugural Discourse has been offered for years. The Library of Congress has located only eighteen copies of his address and not one is privately owned. Because of its rarity and its historical importance in medical history, Dr. Horine felt that this Discourse should be made available to the general reader and student.

STANDARD NOMENCLATURE OF DISEASES AND OPERATIONS, 4th Edition.
Edited by Richard J. Plunkett, M. D., Editor and Adaline C. Hayden, 4 Illustrations; 1,034 Pages; January 2, 1952, The Blakiston Company, Philadelphia 5, New York 22, Toronto 2. Price \$8.00.

This 4th edition of the Standard Guide to Disease and Operations recording for medical record librarians and physicians has been completely revised and brought up-to-date in keeping with medical progress.

Code numbers for acute and chronic conditions are made consistent, new heart diagnoses are included, diseases of the Hemic and Lymphatic system are revised to conform to accepted terminology, the dental and tuberculosis sections are enlarged, and the section on operations includes new operative procedures used in skin grafts and cardiac surgery, the supplementary terms are placed in one section and the disease and operations indexes are placed consecutively in the book.

In addition to these revisions, an International Statistical Classification of Diseases, Injuries and Causes of Death is included. These code numbers are cross-referenced to the standard code numbers.

This 4th edition is the result of three years of extensive work by an editorial advisory board and 21 committees representing each of the individual or specialty sections of the book.

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VOL. 50

APRIL, 1952

NO. 4

Diabetes Mellitus in Office Practice

JOHN S. LLEWELLYN, M. D.

Louisville

The office management of diabetes mellitus has assumed greater importance during the past few years because of the increased incidence and prevalence of the disease and the scarcity of hospital beds. Rarely is it feasible to hospitalize diabetic patients except for the initial period of regulation and for major complications. The general medical supervision of these patients is an office procedure that can be carried out effectively with considerable saving in time and money.

Results obtained from the annual Diabetic Detection Drives and from the intensive screening studies conducted by the United States Public Health Service in several cities indicate that the disease is more prevalent in this country than the previous estimates of one million cases known and under treatment and one million unknown and untreated. Other estimates include four million persons in this country today who will develop diabetes and each will require an average of twenty years of medical supervision and treatment.

Prevalence

During the first half of the century, as a cause of death, diabetes has moved from 27th to 8th place and in some areas the disease causes more deaths than does tuberculosis. As the span of life for the general population increases, so the chance of developing diabetes increases. The young diabetic with better care lives longer and even the female patient passes

through pregnancy to require further care over a longer period of time.

As the incidence and duration of the disease increases, so should the efficiency of handling the problem increase. Most of the problems arising in the care of the diabetic can be efficiently managed in the office and clinic.

Diagnosis

In most cases the diagnosis of diabetes is established in the physician's office. A constant awareness and high index of suspicion is necessary to uncover the signs and symptoms of this pleomorphic disease. Severe cases, those of long duration, and those with complications, present classical symptoms and are not difficult diagnostically. Approximately 23% of diabetic patients present themselves with no symptoms usually attributable to the disease and it is this group that is the diagnostic problem. Glycosuria in any patient should be considered diagnostic until proved otherwise. In a study of 182 patients, Beaser¹ found that glycosuria preceded the development of symptoms by 2-11 years, in 56% of the group urinary sugar had been noted for as long as 16 years, and in 80% for two years before the diagnosis was definitely established. Glycosuria therefore should not be considered lightly even in the face of a normal fasting blood sugar for a postprandial blood sugar or glucose tolerance test will establish the diagnosis unequivocally.

To increase diagnostic accuracy every obese person should be looked upon suspiciously because in susceptible obese persons diabetes occurs earlier and in a more

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severe form, frequently with complications. This is especially true in the female in whom the incidence is higher and also in the Jewish race, that is more prone to develop the disease than the Gentile. A family history of diabetes should always arouse suspicion as some authorities feel that hereditary factors are present in all cases if all the facts were known. A negative family history should not be dismissed lightly before recalling that the onset of diabetes advances approximately 20 years each generation even if the disease is not manifest in one generation². A daughter or son may develop carbohydrate decompensation before the parent or the grandparent develops the disease.

Complications

Our obstetrical colleagues should be alert for potential diabetes and always the obstetrical history of each patient should be searched carefully for tell-tale clues. Obstetrical complications common to diabetes, large babies, toxemia, still births, neonatal deaths, and spontaneous abortions, occur before the disease manifests itself clinically. These complications occur most frequently in the five-year period prior to clinical establishment of the disease³. The birth weight of a child in excess of ten pounds not uncommonly previews the future development of diabetes in the mother⁴.

In other specialties there is opportunity to suspect and tentatively establish a diagnosis. The skin manifestations of diabetes are very common and the genitourinary infections should suggest the possibility to the urologist as should premature calcification of the vas deferens⁵, a relatively specific degenerative complication of diabetes mellitus.

Confirmation of Diagnosis

The confirmation of the suspected diagnosis may be established with relative ease but reliance on glycosuria or fasting blood sugar levels is not dependable. Nor need the patient be subjected to the more expensive and time consuming glucose tolerance test which, if diabetes is present, places an unnecessary carbohydrate load on an already decompensated carbohydrate metabolism. This test is reserved for the doubtful or borderline case. The postprandial blood sugar is a most reliable index of altered carbohydrate metabolism. A blood sugar one hour after a meal of normal carbohydrate content

should not exceed 160 mg.% in young individuals and not more than 180-190 mg.% in the older age groups. Two hours postprandially the normoglycemia level should prevail and 2½ hours postprandially the level should be equal to the fasting level.

General Management

With the diagnosis established the general management of the disease should be started immediately and vigorously. Hospitalization for the initial period of regulation and education is a distinct advantage for many reasons and it serves to impress the patient with the potential dangers of the disease if improperly managed. As a result the patient is more interested, more co-operative, and learns more about his disease and its care.

Blood sugar determinations are easily available in the hospital, adequate control can be accomplished sooner, and the patient has the advantage of instruction from nurses, technicians, dieticians, resident and staff physicians. A diabetic controlled adequately initially and given detailed instruction relative to the disease is in most cases a better patient. He has been started off on the right foot and is inclined to help maintain good control to protect the investment in time and money made toward hospitalization. Investing in early hospitalization is a sound investment in future health from which the patient reaps countless benefits.

The proper and detailed education of the patient relative to his disease is of prime importance and the degree of control in later years is in proportion to the knowledge gained. After the basic principles are mastered the patient learns from his own experience, the experience of others, and from unhurried interviews with the physician. To supplement the knowledge of each patient one of the standard manuals by Joslin, Wilder, or others should be provided, or one of the smaller booklets published by several pharmaceutical houses. To help maintain interest and to supply additional information patients will profit from reading the American Diabetes Association "Forecast," a small booklet with a blue cover symbolic of a negative urine test. It is published in six issues annually and consists of articles by physicians, diabetic patients, and dieticians. There are articles of particular interest to diabetics and a dietary section as well as a question and answer department.

Dietary Management

The principles of the dietary management of diabetes, with or without insulin, have changed considerably during the past few years and an attempt has been made to simplify the quantitative diet and render its preparation less complicated and time-consuming. This change has been based on the belief that a patient will follow more carefully a simple and less restricted diet to the advantage of better diabetic control than is the case with complex diets with many restrictions. A recent poll⁶ of 225 members of the American Diabetes Association indicates that many have simplified their diets using household measures with simplification of fruit and vegetable classifications. The total caloric value of the diet varies according to the age, sex, height and weight of the patient and must be adjusted in accord with the amount of daily physical exertion. High caloric diets are indicated in the underweight and undernourished patient and quantitative restrictions for the obese diabetic is in order. Some feel strongly that in the absence of major complications the obese diabetic should remain on a restricted diet without insulin therapy until normal weight is attained. Although an ideal procedure, it is not always feasible or possible.

Weight Reduction

The reduction in weight of an obese patient reduces glycosuria and hyperglycemia and in rare cases may even return carbohydrate tolerance to normal. The anorexigenic drugs are valuable adjuncts in the weight reduction program and as high as 30 mg. per day may be used⁷. These drugs are not contraindicated by arteriosclerotic or hypertensive cardiovascular disease but must be used with caution in cases with significant myocardial damage. The dose is variable and should be given only before the noon and evening meals. Some success has been experienced in combining the anorexigenic agent with bulk-forming laxatives.

Protein and Carbohydrate Requirements

Without suggesting unnecessary hard and fast rules, the carbohydrate content of the diet should be adequate to maintain normal weight and supply energy needs. Generally this will be in the range of 150-200 grams of carbohydrate daily. Protein

requirements are likewise flexible but should amount to not less than 1 gram per kilogram of body weight per day. Protein is a filling food that helps curb the appetite and, in proper proportions, adds to the smoothness of control in labile diabetes and reduces the number of erratic and unpredictable changes in blood sugar. It aids in the prevention of degenerative renal lesions and maintains normal serum protein levels which, when low, increases liability to infection and secondarily to more serious complications. The amount of fat to include in the diet is controversial because excesses are thought to lead to arteriosclerosis and inadequate amounts prevent or delay the absorption of the fat soluble vitamins A, D, E, and K. The minimal amount necessary to provide a palatable diet and avoid complicated calculation is the rule.

Committee on Diabetic Diet Calculations

To simplify diets generally and to make their preparation less formidable as well as to provide uniformity of diet prescriptions, the committee on Diabetic Diet Calculations was formed⁸. Members include representatives of the American Diabetes Association, the Diabetic Branch of the U. S. P. H. Service, and the American Dietetic Association. From this committee has come the so-called exchange type of diet with foods of similar value divided into six groups according to composition. Each list contains the type of foods and the amount of food with the same caloric value in carbohydrates, protein, and fat. The lists contain milk, vegetables, fruit, bread exchanges, meat exchanges, and fat exchanges. With these exchange lists are six basic diets recommended by the American Diabetes Association ranging from 1200-2600 calories. Because these diets are simple to prepare, easy to understand, and give the patient a wider selection of food, the exchange method of diabetic diet quantitation has been adopted at the Children's Hospital and the Kentucky Baptist Hospital in this city.

Special Foods

Since patients frequently ask, something should be said regarding special diabetic foods. These foods are expensive and the information regarding their caloric content is often in error and misleading. As our dietary management becomes less strict, the need for special foods decrease. They are not recommended.

The Alcohol Question

Invariably the alcohol question arises and its use need not be interdicted on the basis of the diabetic condition alone. Alcohol does supply calories, is thought to have anti-ketogenic properties, and does not form sugar. Dry wines, whisky and brandy are preferable to sweet wines, beer, cordials and champagne as far as the altered carbohydrate tolerance is concerned⁹.

Diet Prescriptions

The diet prescription must be varied depending on the patients' activities, the tendency to hypoglycemic reactions, and the type of insulin used. Between meal feedings and bedtime snacks as well as variable carbohydrate content of the three main meals should be ordered and regulated according to the individual needs. Exercise, a partial substitute for insulin, is indicated where possible and aids in maintaining adequate control.

Use of Insulin

Insulin is the second most important factor in the management of diabetes and most patients whose condition is severe enough to require insulin are taking one of the repository or long acting types. The most popular and most effective of these is the new NPH 50 Insulin; so-named because of its neutral reaction, its protamine content, (0.50 mg. of protamine per 100 units) and the "H" honoring Hagedorn in whose laboratory the insulin was developed.

NPH 50 Insulin, like its popular predecessor the 2:1 mixture, begins its action approximately two hours after injection and has its maximum effect in 10-14 hours with a duration of action 28-30 hours. Patients adequately controlled on the 2:1 mixture can be changed quantitatively to NPH Insulin with maintenance or improvement of the level of control. This new product, which has been available for slightly over one year, is superior to the 2:1 mixture because it requires less time and inconvenience in administration, there is less chance of dosage error, and resulting reactions are more easily recognized. Its use has been associated with a decrease in the incidence of local and general allergic reactions¹⁰.

Due to the slow absorption of this insulin between breakfast and lunch it is advisable to reduce the carbohydrate con-

tent of breakfast to about 50% of the noon and the evening meal. By virtue of its peak action a midafternoon feeding is necessary to avoid hypoglycemia and bedtime snacks will prevent nocturnal reactions. If hyperglycemia is prominent following breakfast the addition of soluble insulin to the morning dose of NPH does not interfere with its quick action because the stability of NPH Insulin is not dependent upon excess protamine but on the addition of a wetting agent. The addition of soluble insulin therefore is a valuable adjunct to therapy in cases of severe or labile diabetes.

Protamine zinc insulin alone or in combination with two parts of regular insulin is rarely prescribed initially in cases of diabetes as the level of control is better with NPH. Most cases on Protamine zinc insulin have been changed to NPH with a resulting decrease in total dosage and better control.

Soluble insulin is still the mainspring of treatment in diabetic acidosis and aids materially as a supplement to repository insulins in the regulation of new-found cases and in labile diabetics.

Experience with globin insulin has been limited but its disadvantages include severe late afternoon shock and its duration of action fails to adequately span a full 24 hour period. After injection its rate of insulin release is variable, giving rise to unpredictable and unexpected hypoglycemic reactions. The control of postprandial hyperglycemia is also poor.

Injection Technic

Since it is a daily procedure for those requiring insulin the injection technic is of great importance. All patients should be encouraged in self administration of the drug and use of the needle-breaking piston-spring injector should be discouraged. The technic taught should effect the deposition of insulin in the loose areolar tissue beneath the subcutaneous fat as this reduces the incidence of local allergic reactions, insulin atrophy of the fat tissues, and subcutaneous insulin tumefactions. There is equal advantage in the frequent change in injection sites, plans of which are included in all manuals and most texts.

Proper Diabetic Syringes

The use of official diabetic syringes¹¹ will avoid errors in dosage and should be encouraged. Three models are avail-

able: the first is for U-40 insulin and has a 1 cc. capacity with the numerals 10, 20, 30, 40 and the line markers in red enamel, the official color for U-40 strength insulin; the second model, also with a 1 cc. capacity, is for U-80 strength insulin and the numerals 20, 40, 60, 80 and the line markers are in green; a third model with a 2 cc. capacity is designed for patients taking more than 80 units daily. The numerals and markers are in green enamel.

Carbohydrate Tolerance Control

Maintaining adequate control of altered carbohydrate tolerance is the major function of the physician in the office practice of diabetes. The adequacy of control can be ascertained from records kept by the patient of the degree of glycosuria in freshly voided specimens taken in the fasting state and three hours after the three main meals. Valuable clues to more effective insulin timing and dosage may be obtained therefrom and beneficial dietary regulation instituted. A more accurate index of control is the blood sugar sampled 1 or 2½ hours after a meal. One hour postprandially the blood sugar should not exceed 180-200 mg. per cent and 2½ hours postprandially the upper limit of 150 mg. per cent should not be exceeded. In the stabilization of a diabetic, postprandial blood sugars need not be at the same level as normal individuals but as nearly so as possible except in the older age groups or in the presence of cardiovascular disease.

Fasting blood sugar levels are a poor index of control since repository insulins continue to act during the period of nocturnal fasting and levels at this time are usually normal or near normal. The efficacy of control, whether by diet alone or diet and insulin, is best determined by the degree of postprandial hyperglycemia. With the urinalysis and blood sugar level as guides, insulin dosage and diet may be changed according to needs, but it is wise to avoid frequent or drastic changes and certainly it is unwise to alter both simultaneously.

Complications

Diabetes is fraught with varied and sundry complications most of which can be prevented or handled well in the physician's office. A thorough knowledge of these complications allows the physician to anticipate trouble and deal with it more

effectively. With the use of insulin diabetic acidosis and coma have decreased tremendously and the incidence of pneumonia and other infections have decreased by more than 50% as a result of more rigid control of diabetes and use of the several antibiotics. But there has been a marked increase in the incidence of cardiovascular disease and premature vascular degeneration¹², related not to the age of the patient but more to the duration and severity of diabetes.

Fatal coronary artery disease is twice that of non-diabetic males and triple that of non-diabetic females. Extremity gangrene is forty times more prevalent in the diabetic and coronary thrombosis with myocardial infarction is the leading cause of death in diabetics today. Our diabetic patients die with their disease but not always of the disease as was the case in years past. The anticipation of and constant search for evidence of premature vascular degeneration allows early treatment and avoidance of more severe complications with progression, so that the patient is offered a longer and more pleasant life unencumbered by cardiovascular infirmities.

Arteriosclerosis

In hypertensive or arteriosclerotic cardiovascular disease the control of the diabetic must be less rigid in an effort to prevent the deleterious effects of hypoglycemia in which there is a marked increase in heart rate, a rise in pulse pressure, and the minute volume output of the heart is increased. These effects on the cardiovascular system can give rise to coronary insufficiency, angina, and even thrombosis with infarction¹³. In hypoglycemia there is also an increased epinephrine secretion and in diabetic patients with hypertensive cardiovascular disease and accompanying capillary fragility the incidence of cortical and fatal cerebrovascular hemorrhage is increased. The less rigid control in such cases is designed to prevent acidosis and maintain blood sugar at compatible levels. Glycosuria in the absence of acetoneuria is allowed as is moderate degrees of hyperglycemia.

Glomerulosclerosis

Intercapillary glomerulosclerosis is another complication of diabetes and, although relatively rare currently, more cases will be seen as it tends to occur more in young patients in the thirties and

forties who have had severe diabetes, poorly controlled over a long period of time¹⁴. It is characterized by proteinuria, edema, hypertension, retinitis, hypercholesterolemia, vascular calcification and cardiac involvement. Before death which may be due to uremia, myocardial infarction, congestive heart failure, or cerebrovascular accident, there is a strange and unexplained decrease in the insulin dosage necessary to control the diabetes. The prognosis in these cases is poor and the only treatment is prophylactic - - rigid control of diabetes.

Insulin Reaction

The most frequent complication of diabetes as seen in the the physician's office is the insulin reaction which is, unfortunately, often neglected or dismissed as being relatively unimportant. A full appreciation of the mechanism of its production and the serious damage repeated or prolonged episodes can cause affords wider opportunity and greater desire to treat it effectively.

The symptoms of these reactions are the direct result of cerebral glycopenia—cerebral glucose consumption is less than cerebral glucose needs—and may occur (a) when there is a profound depression of the blood sugar level uncompensated for by increased cerebral glucose consumption, (b) when the blood-to-brain glucose transfer is diminished, and (c) when cerebral tissues are incapable of utilizing adequate glucose supplies¹⁵. The frequency and severity of reactions vary in the individual and vary from day to day in the same individual. Accountable for this is a variable reaction threshold and there is, therefore, no absolute relation between blood sugar levels and insulin reaction. John¹⁶ has reported a large series of insulin reaction cases in which blood sugar values were normal or high in over 50% of the cases. Varying the reaction threshold are hypocalcemic states and inanition which lower and anticonvulsant drugs and calcium therapy which elevate the threshold.

Ordinarily the changes that occur in an insulin reaction are reversible—the increased adrenalin secretion may mobilize sufficient glucose via hepatic glycogenolysis to allow the patient to respond so he is able to ingest carbohydrate in adequate quantities. In severe or prolonged reactions, however, the cerebral damage may proceed to an irreversible degree with

cerebral edema, meningeal and cerebral hemorrhages, cortical necrosis, disintegration of ganglion cells, and swelling of the glial tissues and axis cylinders. This results in mental deterioration, epilepsy, and even idiocy—all a part of posthypoglycemic encephalopathy.

During reactions there is cerebral dysfunction of an epileptoid nature and some cases of labile diabetes exhibiting abnormal electro-encephalographic tracings have normal or high blood sugar levels. This has been labelled pseudo-hypoglycemic reaction since there is no response to carbohydrate administration, but if such patients are treated with anti-convulsant drugs there is not only a return of the electroencephalograph to normal but there is a decrease in the incidence of reactions and diabetic control is improved¹⁷.

Methods of Controlling Insulin Reaction

In addition to the usual methods of controlling insulin reactions such as lowering insulin dosage, administration of calcium and potassium salts, increasing protein in the diet, and offering between meal feedings, it would seem wise to have electroencephalographic studies to delineate more accurately the causes involved. A trial on anti-convulsant therapy is indicated in patients with recurrent and severe reactions who are refractory to ordinary methods of therapy.

Neuropathic Complications

Diabetic neuropathic complications are relatively infrequent involving approximately one out of every twenty cases. Such complications usually occur during acute infections and after periods of poor control. Involvement of the autonomic nervous system results in orthostatic hypotension as well as gastro-intestinal symptoms such as intractable constipation and recurrent, continuous, or nocturnal diarrhea. Vesical dysfunction and sphincter disturbances are not unusual and in fact diabetic neuropathic disease may run the gamut from simple sensory changes to degenerative joint disease¹⁸. The treatment is again strict control of diabetes and symptomatic therapy since liver extract, vitamin B injections, and vitamin B-12 have been of little value.

Fat Atrophy

Insulin fat atrophy occurs in approximately 30% of insulin treated cases, especially in children and in women, but it

rarely occurs in men. The cause is unknown but it may be prevented by improved insulin injection technic and frequent rotation of injection sites. Injection into areas of insulin fat atrophy, although less painful, results in poor insulin absorption.

Insulin Allergy

Insulin allergy in the local form occurs frequently during the first year of insulin therapy and usually disappears spontaneously. Generalized allergic reactions are rare but occasionally it is necessary to desensitize the patient with frequent and increasing insulin dosages or the administration of antihistamine drugs may solve the problem. Since most insulin is derived from beef, special preparations of pork insulin are available for allergic patients, and some pharmaceutical houses supply special insulin on request.

Insulin Resistance

Insulin resistance of significant degree is rarely encountered but when present a search for the more obvious causes should be made. Resistance may be due to poor absorption from an injection site as is the case of injections into areas of lipodystrophy or as a result of circulatory insufficiency associated with congestive heart failure or shock. Relative resistance may occur in cases of hyperthyroidism and in patients taking thyroid extract. Pheochromocytoma by virtue of the increase hepatic glycogenolysis may also produce relative insulin resistance. True insulin resistance may be associated with insulin neutralizing antibodies in the serum whereas in some cases no cause may be found¹⁹. The treatment of relative and absolute resistance is increasing dosages of insulin until glycosuria and hyperglycemia are adequately controlled.

Treatment of Pregnant Diabetic

The treatment of the pregnant diabetic has become more vigorous and thus more effective during the past ten years. Complications in pregnant diabetics are related to elevated serum gonadotropin levels and decreased excretion of estrogen and pregnandiol. Priscilla White of the Joslin group found a 97% fetal survival rate in one-fourth of 300 pregnant women with normal hormonal assays but in women with abnormal assays the fetal survival rate was only 50-60% and one half of these women had toxemias of preg-

nancy²⁰. Replacement therapy with progesterone and estrogen increased the fetal survival rate to 92% and decreased the incidence of toxemia to 5%. Later studies indicate that stilbesterol therapy is as effective and much less expensive than the naturally occurring estrogens and progesterone²¹. The dosage schedule—details of which can be found in recent texts and publications—range from 5 mg. of stilbesterol per day during the seventh week of pregnancy to 125 mg. daily during the 35th week. Adjunctive therapy includes ammonium chloride (4-20 grams daily) and a low salt type of diet.

Preparation For Surgery

At sometime during the course of the disease every other diabetic will require surgery and the preoperative preparation of the patient can be managed in the office. Strict preoperative control of diabetes, close co-operation between physician and surgeon, and the careful choice of anesthetic procedures will result in a high percentage of operative success. Prophylactic cholecystectomy is recommended for most diabetics with gall stones, whether asymptomatic or not, since the risk is less than if the condition progresses to acute cholecystitis, jaundice, cholangitis, or pancreatitis. Young diabetics with symptoms suggesting appendicitis of a recurring nature deserve prophylactic appendectomy as it eliminates a potential source of future trouble and aids in more accurate differential appraisal of the abdomen in acidosis²².

Conclusions

Problems relative to diabetes mellitus, diagnosis, general treatment, and care of a limited number of complications, have been discussed in hopes that a better understanding of the problems will yield better health generally to the economic advantage of the patient.

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Smith Petersen Nailing With Fibular Bone Grafts As A Primary Treatment For Fractures of the Neck of the Femur

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The last half century has seen great strides in the treatment of femoral neck fractures. It is just 50 years now since Whitman published the first results with the abduction cast treatment. It was his early use of x-rays and studying anatomical specimens that led to the scientific setting of hip fractures. Before that time such an authority as Sir Astley Cooper states in 1822 that he had met with union in only one fracture of the neck of the femur.

Early Surveys

In 1901 Nicholas Senn mailed a questionnaire to 50 prominent surgeons in this country and Europe asking "Does bony union ever occur in intracapsular fractures of the neck of the femur?" The answers were 27 "no," 18 "yes very occasionally," and 5 "do not know."

After three decades of the Whitman treatment the American Academy of Orthopedic Surgery conducted a survey and reported bony union in survivors in the first year of 35.8%. This method carried a mortality in the first year of 23.7%.

In the early thirties Smith Petersen and Johansson introduced the three flanged nail which became very popular and rightly so. After ten years of usage the American Academy of Orthopedic Sur-

gery again made a survey of cases treated by its members and reported bony union in survivors in the first year of 70.0% and a mortality in the first year of 8.5% which was a notable improvement.

Improvement of Technique

Since 1941 numerous improvements in the technique of treatment of femoral neck fractures has added to the percentage of unions. More careful and perfect reduction of the fracture with accurate placement of the nail has lessened the number of non-unions so that survivors at the end of 1951 may have from 80 to 85% union. Still this leaves a group of 15 to 20%, which results in non-union and requires some secondary operative procedure to stabilize the hip for walking.

Aseptic Necrosis

These statistics do not take into consideration the complication of aseptic necrosis which may manifest itself after healing of the neck and subsequent softening of the head occurs. This condition often becomes manifested during the second postoperative year.

Cause of Bad Results

It has been stated by some authors that bad results in fractures of the neck of the femur are the end results of poor nailing. We believe this to be true in some cases; but other factors affect the patient

as well. Good nursing care previous to and following surgery often affects this aged group. If the patient has to do most of the nursing care for one's self then this may put more stress and strain on the fracture site, and in a debilitated patient the chances of survival are less.

Necessity of Having Experienced Operators

It is a well known fact that an experienced operator should have better results than one who does only a few cases each year. Along with this goes the fact that a good operating room setup, with an anesthesiologist and quick x-rays help to lower the mortality rate. Rarely is there any excuse now for an operative mortality in fractures of the neck of the femur.

Value of Patient's Cooperation

One must also calculate the results on whether the patient is cooperative or not. At times patients feel no pain and they bear weight early on the injured member without permission, causing the fractured fragments to come apart. So often in this senile group the patients are somewhat irresponsible and do not follow out the physician's orders and undo some of the good nailing jobs in fractures of the neck of the femur. Often in turning themselves over in bed or getting on a bed pan the patients use the injured member to lever themselves over on their sides. On becoming ambulatory on crutches or in a wheel chair these patients frequently exert too much pressure on the injured member causing the hip fragments to come apart.

We are very conscious of the part that the patient plays in getting a good result.

Other Factors Involved

There are other factors which enter into the healing of fractures of the neck of the femur, and one of the earliest writers

concerning this was Pauwels, a German author who wrote in 1935 of his studies in femoral neck fractures. He concluded there were three types of fractures of the neck of the femur; the abduction; intermediate, and adduction. He also studied the fracture line itself and concluded that the end result in the treatment of femoral neck fractures bears a direct relationship to the obliquity of the fracture line.

Pauwels concluded that abduction fractures are frequently impacted and remain that way. The obliquity of the fracture line is usually less than 30 degrees and rarely do these fractures come apart. Treatment with a Smith Petersen nail usually insures healing in 3 to 4 months.

Pauwels further stated that the intermediate fractures with a fracture line from 30 to 50 degrees to the horizontal are subjected to more active shearing forces than the abduction type. An accurate reduction with perfect nailing will give a fair prognosis as to healing in this type.

Adduction Fractures

Pauwels' conclusions in the so-called adduction fracture with a more vertical fracture line between 50 and 90 degrees to the horizontal is they are a more serious problem. The shearing forces are very active and frequently the prognosis with a Smith Petersen nail is not very good because the fractured fragments pull apart.

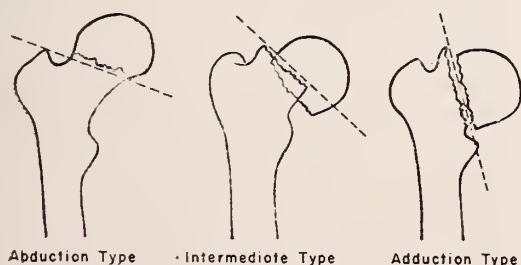
It is in the two latter groups that we are especially interested since our experiences in the past have been similar to Pauwels. A number of authors have used wood screws, wires or an autogenous bone graft in addition to the Smith Petersen nail to secure better fixation.

Use of Smith Petersen Nail

For several years now we have used a Smith Petersen nail and 2 bone grafts from a split fibula to help overcome the shearing forces and movements. We believe it is better than screws or wires because it puts an osteogenic substance in the neck of the femur where bone is not over abundant anyway.

A number of authors have used the Smith Petersen nail and placed it low in the neck with a single fibular graft superior to the nail. In our studies we find that in order for any fracture of the neck of the femur to hold well together the nail must be truly down the center or obliquely upward. We have compromised with

PAUWELS' CLASSIFICATION
OF INTRACAPSULAR HIP FRACTURES - 1935



an attempted excellent position of the nail and the placement of a split fibula graft on each side of the nail; that is one piece on the upper and lower side of the nail. In our series of cases with the usage of the fibular graft it takes us only from 10 to 15 minutes of extra operating time in this procedure. The advantage we feel of extra security outweigh any small increase in operating time. These patients usually however, have more pain in the involved extremity, since we take the fibular graft from the injured side. However, the pain leaves quickly in several days time before the hip pain subsides.

Discussion of Bone Grafting

Our experience with bone grafting along with the Smith Petersen nail is over a three year period. Sixty-six hips have been operated and eight of this number died within the first postoperative year due to non surgical causes, mainly cardiac and embolic accidents. Out of the fifty-eight remaining hips there are forty-one excellent results. Another eight hips have been done too recently for evaluation. Four cases have not been heard from since leaving the hospital. Four cases show questionable results and one is a complete failure. The complete failure was a case of poor reduction and bad nailing. The questionable results are in a group of senile patients only partly co-operative.

Over this three year period we have learned that all intermediate and adduction fractures of the neck of the femur

should not have a bone graft in addition to the nail. A patient who has an advanced senile psychosis or cerebral changes will not cooperate properly to obtain a good result. They get out of bed and walk on the injured hip before it is healed or put too much stress and strain on the hip after the initial pain of surgery has passed. Any patient who is essentially a bed patient before the accident does not need an extra grafting procedure. In the three year period we have treated an equal number of fractured hips with the Smith Petersen nail alone and included in this group those intermediate and adduction fractures whom we do not expect to walk, or are in poor mental health or have had spontaneous fractures due to malignancies.

Conclusion

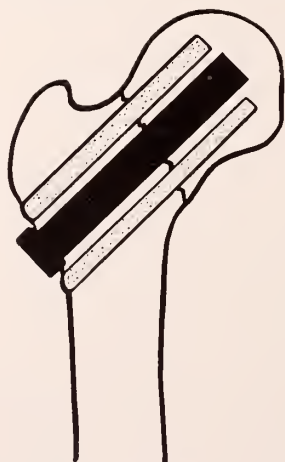
In conclusion we believe that intermediate and adduction fractures of the neck of the femur when fixed with a Smith Petersen nail alone are not always stable. This is due to the obliquity and irregularities of the fracture line. The shearing forces of movements in bed frequently cause the fragments to move in spite of internal fixation. The number of failures of primary healing in the neck of the femur in this group can be lessened by the use of twin fibular bone grafts or one or two long wood screws. The bone graft is preferred because it places an osteogenetic substance in a site where it is frequently needed. Bone grafting in the following group of cases is not advised: In bed ridden patients in poor health, in the mentally ill or in spontaneous fractures due to malignancies.

DISCUSSIONS

K. D. Leatherman, M. D., Louisville: The fibular graft is taken from the fractured side at the time the guide wire is introduced. While the guide wire is being introduced by one team the graft is taken by another team. This requires ten to fifteen minutes extra and of course requires two teams. Good x-ray help is essential. I should like to emphasize that this is a preliminary report and that so far we think it is a superior method of treatment.

Richard T. Hudson, M. D., Louisville: Certainly reduction of the fracture and secure fixation are the important points. Screw fixation with the Smith Petersen nail is often not sufficient. There is one disadvantage of the graft method outlined by Dr. Fischer and that is that it requires two operations or two teams.

Wm. M. Ewing, M. D., Louisville: I disagree



DIAGRAM—Showing ideal placement of a Smith-Petersen nail and two bone grafts.

with the implication in Dr. Fischer's paper that anybody can nail a hip. It certainly requires expert and skillful attention. Fractured femur necks are as dangerous as land mines and Dr. Fischer knows his way about but the results are uncertain for anybody. The results of fractures of the neck of the femur are dependent on the type of fracture and the type of care. I think the two operations at one time may be all right but it is much better if the general surgeon does not have to do this.

C. F. Wood, M. D., Louisville: I should like to take exception to one thing Dr. Fischer said. I believe that it does make a difference whether the graft is driven into the joint or not. If it has entered the joint it certainly increases

the liability to traumatic arthritis and as such is a definite disadvantage. I think the bone graft method described will prevent or at least help to prevent late aseptic necrosis. As we all know this may be quite late, even two or three years after operation. I am not yet convinced that the method described will eliminate the evils and uncertainties of fractured hips.

K. A. Fischer, M. D., Louisville: (In closing) I appreciate the generous discussion of my orthopedic friends and I can only repeat what Dr. Leatherman said that this is a preliminary report. It will be a few years yet before we know whether to keep or discontinue the method.

Malignant Lymphomas (Lymphoblastomas) Medical Aspects-Pitfalls in Diagnosis

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During the sequence of events in Hodgkin's disease and its related disorders enlargement of lymph nodes is almost invariable. The spleen is involved in upwards of 50% of the cases and infiltration of the liver is common. The process may extend to any of the glandular structures such as the thyroid and pancreas and the adrenal and pituitary. The muscles and bones, the bone marrow and periosteum may be involved and the Central Nervous System is in rare instances implicated. Compression of the trachea and esophagus, the biliary system, the ureters, the blood vessels such as the vena cava, and the lymphatics may cause obstruction and distortion of these structures. It is, therefore, almost impossible to give a concise or adequate description of the varied manifestations of these diseases.

Problems in Diagnosis

We are all familiar with the patient who presents with painless enlargement of the lymph nodes about the neck and shoulder girdle, and with splenomegaly. However, it is the individual with malaise, weakness and fever and without outward clinical signs of specific organ or tissue involvement who presents one of our greatest problems in diagnosis. Often he is suspected of having one of the infectious diseases such as brucellosis, tuberculosis, infectious mononucleosis, sub-acute bacterial endocarditis or typhoid fever. Yet it is just this type of case and at this stage that we have much to offer with specific therapy in the relief of symptoms and the return of the individual to a useful life.

Areas Involved

In about 10% of patients suffering with Hodgkin's disease the granulomatous process is restricted to the thorax or abdomen. Under these circumstances the recognition of this disease becomes extremely difficult. Longcope reports the following mistaken diagnosis in a series of such patients.

Liver abscesses	2 patients
Cholelithiasis	2 patients

Brain tumor	2 patients
Carcinoma of the lung	1 patient
Esophageal stricture	1 patient
Carcinoma of the G. I. Tract	1 patient
Duodenal ulcer	1 patient
Rheumatic fever	1 patient
Pyelitis	1 patient
Polyserositis	1 patient
Aplastic anemia	1 patient

Erroneous diagnosis as varied as these have been reported by many observers.

Extraneous Symptoms

Painless jaundice is not uncommonly the presenting complaint of a patient with Hodgkin's disease. Still, in the absence of peripheral lymph node enlargement one is apt to overlook the possibility. Dyspnea is perhaps a more common presenting symptom than jaundice. Fortunately, however, physical examination and roentgenogram of the chest frequently reveal the presence of lymph node enlargements in the mediastinum and the diagnosis is suspected. Signs of systemic involvement, fever, sweats, tachycardia, weakness and weight loss are common to all the malignant lymphomas and are certainly non-specific. Because of various toxic and hemolytic factors and for mechanical reasons anemia and a bleeding tendency may be manifested by many of the diseases under discussion.

Early Symptoms and Signs

Painless superficial lymph node enlargement is the first sign of Hodgkin's disease in the majority of cases and the cervical region is the area most commonly involved. Pain is the second most frequent symptom; however, this is comparatively rare. In the sarcomatous form of Hodgkin's disease and in the lymphosarcomas, especially reticulum cell sarcoma pain and weight loss are common. This pain is usually localized to the back and abdomen. In obscure back pain resistant to the usual forms of therapy a search for lymph node enlargement may give the clue to the proper diagnosis. Involvement of the gastrointestinal tract by these diseases frequently may simulate carcinoma, ulcerative colitis or enteritis,

peptic ulcer, or obstruction of the bowel. When this occurs coincident involvement of the peripheral lymph nodes is infrequent. The bone lesions in Hodgkin's disease do not give a characteristic x-ray picture and must be differentiated from metastatic carcinoma. Frequently they are confused with Ewing's Tumor, osteogenic sarcoma, osteomyelitis or multiple myeloma. Involvement of the vertebrae with collapse of the body or invasion of the epidural space from involved retroperitoneal lymph nodes may lead to neurological lesions.

Clinical Differentiation of Hodgkin's Disease from Other Lymphoblastomas

Giant follicular lymphoma is a relatively benign tumor whose clinical picture often closely resembles the less malignant forms of Hodgkin's disease. Its chief danger lies in its tendency to change into one of the more malignant of the lymphomas. Occasionally they are associated with a rapidly reaccumulating pleural effusion which requires frequent thoracentesis for relief of symptoms.

Lymphosarcoma cannot be distinguished from Hodgkin's disease with any degree of certainty without a biopsy and histopathological examination of the tissue so removed. The superficial lymph nodes when enlarged are usually painful and firmer than those seen in Hodgkin's disease and they frequently are of a stoney hard consistency that is commonly associated with metastatic carcinoma. Pronounced fever is rare unless associated with sepsis and spontaneous remissions are said not to occur.

The lymphocytic type of lymphosarcoma may co-exist with lymphatic leukemia. It is a highly invasive tumor in which metastases are infrequent. The tonsil is often the site of this disease. Reticulum cell sarcoma may also originate in the tonsil but this is less common. This condition is more prone to start in the retroperitoneal lymph nodes or in the viscera where they are commonly mistaken for carcinoma. When it is primary in the bone metastases occur late and then chiefly to the neighboring lymph nodes. The long bones are the usual sites of involvement and symptoms other than local are rare except after metastases have occurred. A high percentage of long time cures is said to follow early therapy of these primary osseous lesions and of those that are primary in the gastrointestinal tract.

Diagnosis, Methods and Pitfalls

While it is sometimes possible to make the diagnosis on clinical grounds alone the specific diagnosis rests on the microscopic examination of the involved tissues. In the presence of superficial lymph node involvement biopsy is the standard procedure. In the absence of accessible nodes it may be impossible to make the diagnosis with procedures ordinarily employed. Early exploratory laparotomies and thoracotomies are to be encouraged because with the diagnosis once established it is frequently possible to give the patient remissions from his disease. The use of x-ray irradiation to the chest as a diagnostic procedure has been suggested in those cases where mediastinal and pulmonary involvement is present. This is to be discouraged for several reasons. If tuberculosis is present it may be reactivated. If a benign tumor is present it should be extirpated and finally other tumors including carcinoma may respond to x-ray so that the use of x-ray therapy for diagnosis has little to offer and is potentially of much harm. Bone marrow aspirations are frequently of some help in all these conditions. The peripheral blood picture is of little use except in differentiating the leukemias and infectious mononucleosis. Hodgkin's disease, especially in the active phase, may be associated with a leucocytosis of 20,000 or 30,000 or more with an increase in the percentage of polymorphonuclear leucocytes. Infrequently there may be a peripheral eosinophilia. Leukopenia may occur, especially in the late stages of the disease and also as result of therapy. Not infrequently, however, leukopenia if due to hypersplenism or to bone marrow involvement can be corrected with specific therapy. Hodgkin's disease may also be distinguished from tuberculosis by the absence of a reaction to tuberculin.

Management*

Adjunctive therapy is of considerable importance. The correction of anemia with whole blood transfusions and with infusions of washed red blood cells has permitted the more intensive use of specific therapeutic measures and has been of much help in treating cardiac complications from this cause. The use of iron, liver extract and vitamin B12 is valueless unless a specific deficiency exists. The treatment of cardiac decompensation with rest, digitalis, salt restriction, diuretics and

*Specific Management With Radiation Therapy and Chemotherapy was discussed by another participant and will be published shortly.

oxygen is well known. The maintenance of an adequate nutritional state is important and the use of supplemental vitamins may have a real place in the therapeutic regimen. Leukopenia is no longer a dreaded complication of therapy since the advent of the antibiotics and their use prophylactically to prevent sepsis. The subcutaneous and intramuscular route for the administration of these drugs should be avoided because of the frequent occurrence of painful hematomas. Antipuritic measures are of considerable value in making the patient's plight more bearable. The recent successful use of ACTH, cortisone and of muscle adenylic acid for control of itching represents distinct advances in the management of these conditions. The control of a bleeding tendency with whole blood transfusions and with the intravenous administration of protamine sulphate and of toluidine blue is frequently life saving. Pressure symptoms due to ascites and pleural effusions are relieved by the appropriate paracentesis. Edema, except when due to cardiac complications, is usually the result of hypoproteinemia and to obstruction of the regional lymphatic and venous channels. Specific therapy to relieve such blockage and dietary measures to raise the serum protein levels are frequent-

ly useful. The use of sedatives and of analgesic and antipyretic measures is not to be overlooked.

In closing I should like to emphasize the importance of early diagnosis in the malignant lymphoma. As has been indicated much can be done to relieve the patient of his symptoms and to return him to a useful and productive life.

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Less Common Surgical Lesions of the Gastro-Intestinal Tract, Case Reports

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Three surgical lesions of the gastro-intestinal tract occurring relatively infrequently are Leiomyoma of the Stomach, Nonspecific Ulcer of the Small Intestine, and Adenocarcinoma of the Ileum. In most instances, the presence of one of these lesions is not suspected until one or more complicating factors becomes clinically evident. These factors are either hemorrhage, perforation or obstruction. Early diagnosis of these less commonly occurring lesions before complications arise can only be accomplished by suspecting their presence in those patients complaining of vague gastric discomfort, fatigue, distention, and mild abdominal cramps. The most valuable aid to early diagnosis is

thorough x-ray studies by a roentgenologist experienced in this field. Early diagnosis and immediate operation before the onset of obstruction, perforation, and malignant invasion are the only measures which will insure the lowering of a very high mortality rate.

The case reports are presented, not as a tribute to personal experience, but rather to exemplify briefly the clinical characteristics and treatment of three relatively rare surgical conditions of the stomach and small intestine.

Leiomyoma of the Stomach

According to Boyd, leiomyoma of the stomach is the most frequently occurring benign tumor of the stomach, but is relatively infrequent when compared to car-

cinoma. Minnes and Geschickter found that leiomyoma formed 36.6 per cent of all benign tumors of the stomach. Its incidence is about equally distributed between males and females. Leiomyoma arises from the muscularis, usually the fundus near the cardia but may arise near the pylorus, in fact, Matas has reported a pediculated leiomyoma which acted as a ball-valve producing intermittent pyloric obstruction.

The etiology of leiomyoma has never been established. A few writers are of the opinion that uncontrolled smooth muscle proliferation during the healing phase of gastric ulcer is of etiological significance. Histologically, it is indistinguishable from leiomyoma of the uterus and calcium deposits scattered throughout the tumor are common.

Classification

Leiomyoma of the stomach is classified as either sub-mucous (intra-gastric) or sub-serous (extra-gastric). The former is most likely to be of greater clinical significance because it is in this group that the pathological changes of necrosis, ulceration and hemorrhage are found. Hematemesis and melena are the predominant subjective findings with fatigue and weakness next in order due to secondary anemia. Another pathological change of clinical importance which may occur in either the sub-mucous or sub-serous variety is sarcomatous degeneration. Of seven cases reported by Lahey and Colcock, five or 71% had undergone sarcomatous changes. In a larger group of cases such an incidence of malignant change would probably be lower.

Diagnosis

The diagnosis of leiomyoma of the stomach depends upon the roentgenologic findings plus the physician's appreciation of the occurrence and clinical importance of these tumors particularly in those patients who present themselves because of gastro-intestinal hemorrhage. The gastric analysis is always within normal limits. A rounded, firm, highly mobile tumor of the epigastrium in those with a palpable mass is the most outstanding objective sign of leiomyoma. Should the tumor at operation be localized and mobile then it is impossible to determine by inspection whether it is malignant or benign. Frozen section of the excised tumor by the pathologist is of utmost importance as a

guide in determining whether simple excision is sufficient for cure or if gastric resection should be performed.

Case Report

CASE 1: Mrs. M. A., a 65-year-old white female was admitted to the hospital because of sudden hematemesis earlier in the day. She estimated the amount of blood to be between 1 and 2 pints. She gives a history of having had vague epigastric discomfort for the past 8 years. Her discomfort had never been severe and there is no established diagnosis of peptic ulcer in the past. She has never had a roentgenologic examination of the esophagus and stomach. She is slightly obese, not acutely ill, but moderately pale. The pulse is 90 and the blood pressure 120/80. The physical examination is not remarkable. There is vague tenderness in the epigastrium on deep pressure. There are no palpable masses and the rectal examination negative. The clinical impression was bleeding gastric ulcer or carcinoma. Urinalysis is essentially negative; RBC 3,360,000; hemoglobin 10.2 gms.; WBC 9,100; Polys 73%; lymphs 27%. A barium meal was interpreted by the roentgenologist as follows: There is a fixed, rounded, smoothly outlined, polypoid mass measuring 5 cms. in diameter in the cardiac portion of the stomach. Its general appearance suggests that the lesion is benign, however the possibility of malignancy cannot be excluded.

The patient was prepared for surgery by administration of blood transfusions and fluids.

Operation: On 8-10-51 the stomach was approached transthoracically after resecting approximately 85% of the left 7th rib. The left diaphragm was opened and the cardia delivered into the left pleural cavity. The anterior wall of the stomach was incised obliquely and the tumor found attached to the posterior wall of the cardia, pediculated, mobile and containing an area of necrosis 2 cms. in diameter. Clamps were placed across the pedicle and the tumor excised for biopsy. Frozen section revealed a leiomyoma. The mucosa was sutured with a running row of intestinal catgut. Incisions in the anterior wall of the stomach, diaphragm and left chest wall were closed in layers without drainage.

Pathological diagnosis of the tumor was benign, leiomyoma from wall of stomach, projecting as polypoid mass into the stom-

ach and chronic ulceration of gastric mucosa on surface of leiomyoma.

Her post-operative course was uneventful and she was dismissed from the hospital on the 8th postoperative day. She has remained well.

Comments

This case very vividly illustrates the value of barium studies of the stomach when one complains of continuous gastric discomfort, flatulence, eructation, and fullness. She had complained of the above symptoms for eight years without the benefit of upper gastro-intestinal roentgenologic examination. Sarcomatous changes in an otherwise benign tumor might well have occurred over an eight year period before the onset of hemorrhage. Some favorable characteristics toward benign leiomyoma of the stomach are a well circumscribed rounded mass, pediculated and very mobile. If these characteristics are present one is safe in simply excising the tumor above clamps for immediate frozen section. Such was the surgical management of this case. Her postoperative period was uneventful. Blood in the amount of 3000 cc was administered before operation. She has remained well.

Primary Nonspecific Ulcer of the Small Intestine

A comprehensive study of the literature concerning nonspecific ulcer of the small intestine was made in 1948 by Evert, Black and Dockerty at the Mayo Clinic. They found a total of only 130 cases including 14 from their own clinic. In 1951 Shea of Emory University reported 5 cases which were seen in the past 3 years in a city hospital which admits a yearly average of 22,000 patients. In other words 5 out of approximately 66,000 patients had a diagnosis of nonspecific ulcer of the small intestine. At the Mayo Clinic the incidence was much lower being approximately one per 100,000 patients.

Solitary ulcer of the small intestine, in the absence of any other disease process in the bowel, is designated primary or simple nonspecific ulcer. The etiology of the ulcer, whether acute or chronic, is unknown. Some of the causative factors mentioned in its etiology are infection, trauma, thrombo-embolic phenomena, and heterotopic gastric mucosa. No one has been able to demonstrate gastric tissue about the ulcer area. Syphilis and tuber-

culosis have been excluded as possible etiological agents in most cases.

The typical primary ulcer is a small punched out area of mucosa with little induration about its margin or the surrounding tissues. The wall of the intestine is thickened at the ulcer area with some narrowing of the lumen but without serosal evidence of disease. They are usually chronic and asymptomatic unless such complications as perforation, hemorrhage or obstruction develop. Of all the reported cases 62 per cent were found in the ileum and 38 per cent in the jejunum. It appears that the lesion is often found only a short distance from the duodeno-jejunal flexure and ileo-cecal valve. The average age is 43 and the ratio of males to females is 3 to 1.

Diagnosis

The diagnosis of primary ulcer of the small intestine is seldom made pre-operatively. It is useful to think of this possibility in the following groups of patients: (1) Patients with unexplained gastro-intestinal hemorrhage and negative roentgenologic examination; (2) Patients with symptoms and signs of peritonitis in whom no gastric or duodenal perforation is seen at operation.

Complications

The complications of primary ulcer of the small intestine; namely: perforation, hemorrhage and obstruction make it potentially dangerous for the reported mortality rate is between 50 and 65 per cent. Perforation is the most common complication since it occurred in 81% of all recorded cases, bleeding in 15%, and clinical obstruction in only 9%.

Case Report

CASE 2: Mr. H. F., a 57-year-old white male was admitted to the hospital because of sudden profuse rectal bleeding. A few hours before admission to the hospital he passed a large quantity of mixed bright red and dark blood. Appendectomy 24 years ago but no illnesses since. Digestion excellent, good appetite, no abdominal cramps, diarrhea or constipation. The physical examination was not unusual, B/P 106/64 and the pulse 90. Abdomen soft, no tenderness elicited. There are no palpable masses. Rectal examination negative except for dark blood on the gloved finger. Urinalysis was essentially negative; RBC 2,770,000; hemoglobin 8.2 gms.;

Blood Urea Nitrogen 12 mgms %. The clinical impression was carcinoma of the right colon. Proctoscopic examination and barium enema were negative. Roentgenologic examination of the upper gastrointestinal tract was as follows: The stomach is negative. The duodenal cap shows a minimal contractive deformity superiorly, however a definite ulcer crater cannot be demonstrated. The duodenal loop is negative. An attempt to restore the circulating blood volume with blood transfusions and fluids failed because of continuing hemorrhage. Abdominal exploration was done through an upper left rectus muscle splitting incision. The stomach and duodenum were normal. Exploration of the small bowel revealed a moderately firm thickened area near the mesentery located approximately 20 cms. proximal to the ileo-cecal valve. The serosa was not involved and no appendage could be demonstrated. Resection of the small bowel was performed removing approximately 15 cms followed by end to end anastomosis.

Pathology

Gross. The specimen consists of a short segment of the terminal ileum taken approximately 10 inches from the ileo-cecal valve. Within the segment of ileum there is an ulcer crater on the mesenteric border. The ulcer measures .7 cms. in diameter. The mucosa shows puckering toward the ulcer.

Histopathology

Sections through the lesion show a chronic ulcer in which the base shows granulation tissue with polymorphonuclear and lymphocytic infiltration. The surrounding mucosa is edematous and infiltrated with polys and eosinophils. In the ulcer crater there is a deposit of fibrin. The wall of the bowel for considerable distance shows an excess of lymphoid tissue in the submucosa. The muscularis shows no evidence of infiltration by neoplastic cells.

Diagnosis

Primary ulcer of mucosa of terminal ileum. His postoperative course was uneventful and he was dismissed from the hospital on the 8th postoperative day. He has remained well for three months.

Comment

This case clearly demonstrates the value of thorough search of the small

bowel at operation when hemorrhage cannot be accounted for in the stomach, duodenum, and colon. Fortunately for this patient severe bleeding from the lower gastro-intestinal tract occurred as the first complication of his lesion rather than perforation, for the latter occurs much more frequently and is accompanied by a very high hospital mortality rate. Adequate restoration of his blood circulating volume with blood and fluids before small bowel resection contributed materially to an uneventful postoperative period. When last seen 2½ months ago he had remained perfectly well, regained his original weight, and had experienced no bleeding from the rectum.

Adenocarcinoma of the Small Intestine

The incidence of adenocarcinoma of the small intestine is rare when compared to that of cancer of the stomach, colon and rectum. Most writers estimate that carcinomas of the small intestine form about 1% of the carcinomas of the gastro-intestinal tract including the stomach and rectum. A review of all the adenocarcinomas of the small intestine treated at the Mayo Clinic from 1907 to 1947 was made by Pridgen, Mayo, and Dockerty. There were 63 microscopically proved adenocarcinomas of the small bowel. Forty-four lesions were in the jejunum and 19 in the ileum.

Nineteen of the 63 microscopically proved adenocarcinomas of the jejunum and ileum were operated upon by Rankin and Mayo in the period from 1919 to 1929. One of their patients had multiple cancers of the small bowel. They found that the average duration of symptoms was 14 to 15 months and that the signs and symptoms are directly related to chronic intermittent intestinal obstruction. They emphasized the importance of roentgenologic examination and anemia. Constipation and loss of weight were frequent.

The average age for the Mayo Clinic group was 49.2 years. The ileac cases were divided equally among males and females while the jejunal lesions predominated in the males in the ratio of 2 to 1.

Clinical Signs and Symptoms

Perhaps the earliest clinical sign of carcinoma of the small intestine especially if located in the ileum is anemia manifested by weakness, continued tiredness, fatigue, and dyspnea on exertion. As the tumor

increases in size thereby encroaching upon the lumen of the bowel signs of intermittent chronic obstruction make their appearance. These signs are cramping pains throughout the abdomen usually most pronounced about the umbilicus, distention and nausea with occasional vomiting. This phase of tumor growth should cause the physician to entertain the idea that a small bowel tumor might be present. Those tumors producing partial or total obstruction are frequently diagnosed preoperatively. A scout film of the abdomen which reveals mechanical obstruction of the small bowel is sufficient indication for surgical exploration.

Melena occurs rather frequently as in many lesions of the gastro-intestinal tract, but small bowel tumor as a possibility of its source should never be ignored. Perforation was found to occur in 33% of the cases studied. This is a grave complication. Generalized peritoneal contamination secondary to perforation most frequently accounts for the high hospital mortality rate associated with bowel resection.

Treatment and Prognosis

The operable cancers are treated by wide radical resection of the small bowel and its portion of mesentery with primary anastomosis. The inoperable group is benefited temporarily by a palliative short-circuiting operation around the growth.

The overall prognosis is poor for most adenocarcinomas of the small intestine are of high grade with invasion of local and distant lymph nodes. About 65% of those with high grade lesions live only 1 to 3 years. Only about 12% of the patients fall into the low grade group which offers a life expectancy of 10 or more years.

Case Report

CASE 3: Mr. J. E., a 61-year-old male was admitted to the hospital on 11-9-49 because of severe abdominal pain, hiccoughs, and vomiting of 10 hours duration. For the past 3-4 weeks he had experienced intermittent abdominal cramps, nausea, and distension. He would vomit occasionally followed by temporary relief from cramps. The stools have been fluid for the past week. He was obviously very ill, considerable pain, almost constant hiccoughing and moderately dehydrated. Temperature 99°, pulse 120; respiration

30; blood pressure 100/65. The abdomen was markedly distended, tender, and resistant 3 plus on a basis of 4. No masses. Occasionally peristaltic wave was heard. Urinalysis was essentially negative; RBC 5,870,000; hemoglobin 17.3 gms.; WBC 8,250; polys 87%; lymphs 12%; blood chlorides 358 mgms. %. The clinical impression was acute small bowel obstruction. A scout film of the abdomen was interpreted as follows: There is rather marked distention of the small bowel. The degree of distention is such that mechanical obstruction is the diagnosis of choice. There are some features suggesting that it may be incomplete.

After the administration of 2000 cc of 5% glucose in normal saline the abdomen was opened through a right rectus muscle splitting incision. Small bowel contents in the amount of 300 to 400 cc were immediately encountered. The terminal ileum was bound down in the pelvis, markedly dilated, and there was marked thickness and edema about the ileo-cecal coil. There were two areas of necrosis in the terminal ileum which measure 8 to 10 cms. There are several perforations scattered along the areas of gangrene. One of the perforations was adjacent to the ileo-cecal valve. Several large glands were noted in the mesentery of the ileum. A resection of 24 inches of the terminal ileum, cecum, and right colon was done followed by ileo-transverse colostomy by lateral anastomosis. One penrose drain was placed in the right gutter and one in the pelvis bringing both out a stab wound lateral to the incision, 500 cc blood transfusion was given during the operation.

Histopathology

Sections through the thickened portion of the terminal ileum show that this area is infiltrated by neoplastic growth which fairly well infiltrates the submucosa and the muscular coats but does not infiltrate to the serosa. This neoplastic growth is of a very low grade type of malignancy and forms large glands and shows very few mitotic figures. The glands have a normal appearance on first inspection, but on comparing with the glands in the normal portions, they are seen that the nuclei are much larger, and the cells do not produce mucus in a normal fashion. The cytoplasm also has a dark smoky, pinkish-blue appearance. The nuclei also occupy the central position of the cells. Sections through the ileum in

the areas of perforations show that the wall is not involved by the neoplastic process, but the blood vessels appear to be engorged. The surrounding tissue has a very eosinophilic staining characteristic which appears to be infarcted. The tissue appears to be rather diffusely infiltrated with inflammatory cells, consisting of lymphocytes and polymorphonuclear leukocytes. Sections through the colon and other portions of the ileum show a very extensive peritoneal inflammatory reaction on the serosa of the bowel, due to the rupture in the terminal portion of the ileum.

Diagnosis

Grade 1, adenocarcinoma of the terminal portion of the ileum, with invasion of the submucosa and muscularis mucosa, but no invasion of the serosa. No tumor involved lymph nodes were found.

Obstruction of the terminal ileum, due to the neoplastic process. Dilatation of the immediate preceding portion of the ileum, due to the obstructing process with obliteration of the blood vessels and infarction of the wall.

Perforation of the terminal ileum in the area of infarction.

His early postoperative period was stormy because of sepsis, peritonitis and extensive surgery. Wound infection developed on the 5th postoperative day leading to dehiscence on the 7th postoperative day. He was immediately taken to the operating room for secondary closure of the wound. He gradually improved during the 2nd postoperative week and was eating soft foods on the 15th postoperative day. The Miller-Abbott tube was removed on the 12th postoperative day.

Treatment

During the period of severe sepsis he was given penicillin, streptomycin and frequent small blood transfusions. Because of extensive wound infection he was not dismissed from the hospital until the 36th postoperative day. He has remained well and was asymptomatic on 2-8-52.

Comment

This case beautifully demonstrates most of the surgical lesions encountered in the small bowel; namely: tumor, obstruction, thrombosis, infarction, perforation and obstruction. His stormy con-

valescence is attributed to the long duration and severity of his illness and multiple complications. Too, unavoidable violation of a cardinal surgical principle because of the lesions anatomical location; namely, massive resection in the presence of obstruction, perforation, and generalized peritonitis contributed greatly to his eventful postoperative course. A scout film of the abdomen taken one week earlier would have made the diagnosis of mechanical obstruction of the small bowel.

Adenocarcinoma of the ileum grade 1 which has not invaded the serosa or local glands in the mesentery provides a good prognosis and he should well fit into the 10 year or longer survival group.

Summary

Three surgical lesions of the gastrointestinal tract occurring relatively infrequently are presented with case reports. They are Leiomyoma of the Stomach, Nonspecific Ulcer of the Small Intestine, and Adenocarcinoma of the Ileum. In most instances, their presence is not suspected until one or more complicating factors become clinically evident. These factors are either hemorrhage, perforation, or obstruction. Such early subjective symptoms as vague gastric discomfort, fatigue, distention, and mild abdominal cramps should cause one to entertain the possibility that one of these lesions might be present. The most valuable aid to early diagnosis is thorough x-ray studies by a roentgenologist experienced in this field. Early diagnosis and immediate operation before the onset of obstruction, perforation and malignant invasion are the only measures which will insure the lowering of a very high mortality rate.

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Special Articles

The Problems of the American Medical Association and the County Medical Society

LOUIS H. BAUER, M. D.

President-Elect

American Medical Association

Hempstead, New York

I am delighted to have the opportunity of talking before this group today. Just as a chain depends for its usefulness on the strength of its individual links, so the American Medical Association depends upon the strength of its constituent associations and component county societies.

You are the American Medical Association. The group in Chicago, at the headquarters office, is only trying to carry out your ideas and desires.

There was a time when the County Society was a dominant force on health matters in the community. In some areas it still is, and it still should be. Unfortunately, however, in many areas, the County Society has lost its position of leadership, because of the indifference of many of its members. County Society meetings are often poorly attended and if any of the socio-economic problems of the profession are to be discussed, the attendance is even more meagre.

The time has long passed since the physician and the County Society could think of and act on scientific matters only. Medicine today is no longer just a matter of doctor-patient relationship. In fact, even that relationship is endangered by some of the trends existing today.

Today the physician must be alive to preventive medicine as well as curative medicine. He must be interested in the health education of the public, and he must take into careful consideration the economic problems which have arisen in connection with the delivery of medical care.

Government has come to play an increasing role in medicine. To a certain extent this is essential. For example, en-

vironmental sanitation; control of communicable disease; control of milk, water and food supplies; public health laboratory service are all functions of government as they pertain to communities, as well as individuals, and a police power is necessary to carry them out.

Because of the rising costs of hospitalization and medical care, some solution had to be found to ease these costs on the individual patient. Two methods have arisen, both of the prepaid type—one, compulsory and sponsored by governments and the other voluntary, sponsored by physicians and others who believe in complete freedom. The voluntary method must be made a success or the compulsory method will be forced upon us. Whether or not it is a success will depend largely on the medical profession. Today, there are still many physicians who are not only not enthusiastically behind the voluntary program, but some who are openly hostile to it. I can understand a physician being hostile if he believes in socialism, as success of the voluntary method will defeat this marked socialistic trend, but I cannot understand a physician being hostile or even uncooperative, if he believes in the freedom of medical practice. He may wish he could practice medicine as it was practiced 25 years ago, but he cannot and he, in all probability, never will be able to again. We must face conditions as they are, not as we might like to have them.

Our voluntary program has made tremendous strides and millions are being enrolled in it each year. It will not solve the problem however, until all physicians are whole-heartedly behind it and we have closed the gaps still existing in coverage. These gaps are protection of those over 65, protection against financially catastrophic illness, and further avail-

ability of individual as well as group coverage.

In some areas, the medical profession has lost caste, because a few physicians have overcharged their patients and have thus given the whole profession a bad name in the eyes of the public. The establishment of grievance committees has been a forward step in eliminating this abuse, but unless medical societies are adamant in disciplining those few members who blatantly disregard the recommendations of the grievance committee, the latter will be of no avail. Oftentimes, the difficulty is not overcharging, but a lack of understanding on the part of the patient as to the value of the services rendered. Physicians should take time to explain to their patients why certain procedures are necessary and what they will cost. Physicians also should be careful not to order procedures which are unnecessary to make a diagnosis, but which are merely time-savers for him. The American Medical Association has recently recommended that every doctor have the following plaque in his office, reading—

"TO ALL MY PATIENTS—

I invite you to discuss frankly with me any questions regarding my services or fees. The best medical service is based on a friendly, mutual understanding between doctor and patient."

The use of such a plaque will not only improve relations between the physician and patient, but will avoid many misunderstandings and complaints to the grievance committees.

Too many doctors are unwilling to make calls at night or on holidays. Nothing irritates the public or hurts the medical profession more than the public being unable to get a doctor when it wants one. The emergency panels which have been set up in many areas are an answer to this, but they are not established in every area. In New York County during 1951, over 3800 calls were handled by the emergency panel. In each case it was only a matter of minutes from the time the call was received until a physician was on his way.

It is important that diagnostic facilities be available within easy reach of every community. This does not mean that they must be available in every physician's office nor necessarily in every town or vil-

lage, but they should be available within a reasonable number of miles. Such availability will make for better, cheaper medical care, and there will be less difficulty in persuading physicians to settle in small communities. Well-trained physicians desire to practice good, modern medicine and to do so they must have adequate facilities.

The indigent are a problem for nearly every community. Agreements between the medical profession and local government agencies have solved the problem in some areas, and such agreements should be made in all areas.

We must inculcate those entering the practice of medicine with the tradition of medicine—namely, that medicine is a public service. Those individuals who practice medicine only for what they can get out of it financially, are not a credit to the medical profession. Motives of profit are not within the scope of medical ethics. The physician is, of course, entitled to a reasonable emolument for his services, but for centuries it has been the tradition of the medical profession to render service wherever needed, regardless of the ability of the patient to pay.

In the government sponsored plans often the physician does not receive a satisfactory recompense and his service suffers because of it. The lack of competition, the red-tape, the interference with treatment, the rising costs of government sponsored or government administered schemes result in deterioration of the type of medical care rendered. More and more centralization of control results from the tendency to expand the system and the rising deficits. The physicians are utterly ignored.

In a recent questionnaire sent out by the International Labor Organization to governments, as to the provision of medical care in the various countries, there is no evidence that any professional medical association was consulted by its government, when replies to the questionnaire were prepared.

A recent report rendered to The World Medical Association states, "If medical care under social security is established according to party politics and theoretical speculations, without contacts with those who must serve under its directives, the system may appear good on paper and to the unenlightened, and yet be bad for all. Under such circumstances, the doctor may be deprived of his freedom and the pa-

tient of his will to help himself, thus disturbing the personal relations between them to the disadvantage of the community."

Medicine is no longer merely a problem for the physician, it is a problem for the community as well. The public must be given health education. Many groups, professional and semi-professional, have an interest in health. Community Health Councils, recommended by the American Medical Association, can solve many problems in a local area, but the medical profession should sponsor and head these councils. If the medical profession is lag-gard in this regard, others will take the initiative and not always the best leadership will be forthcoming.

I hope I have made it clear that there are many problems besetting the medical profession, today, besides purely scientific ones. The medical profession is best suited to solve these problems and to direct other groups which have an interest in health. If the profession does not face the issues squarely nor give time and effort to their solution, the results are not going to be happy for either medicine or the public.

I urge you, therefore, to arouse your members and to persuade them to take an active interest not only in medical science, which is their first love, but in socio-economic problems as well. The future of medicine in this country depends on an alert, informed, active profession. Physicians must not only be physicians, but they must be interested and active in civic affairs.

There is a trend in this country towards destroying our heritage and free institutions. We are rapidly traveling down the road to complete socialism. Unless this trend is checked, not only will medicine become an assembly-line product, but our entire economy and American way of life

will be destroyed. I urge the medical profession to spearhead the drive for the maintenance of freedom in America.

Make your county society committees active. Give everyone a chance to work. Select men to head these committees and to become officers in your society who are willing to sacrifice time and devote effort to protecting the future of medicine and of the country. Impress upon your members that the hour is late, "later than you think." It is often said that if one wants anything done, he should get a busy man to do it. There is enough work in any county society to make everyone busy. It is particularly important to make the criticizers busy. Any society is the product of its members. If the society is not accomplishing anything; or if some of the members do not like what the society does, it is the fault of the members. An active, alert membership can accomplish anything it sets out to do, and no society is ever going to adopt any policy of which its members do not approve. If it does, it is because the members have not expressed themselves and have let things go by the board. Once a society becomes active, and exerts leadership in the community, it will engender respect and its advice will be accepted and followed.

The Right Honorable Sir Earle Page, Minister of Australia, has said that it is impossible to make any plan work which will not enlist the cooperation of those who have to carry it out. In other words no health plan can be carried out without the help of the physician.

Let us go farther than that. Let us see to it that the planning for any phase of health in any community is led by the medical profession and if that planning is sound, we shall enlist the cooperation of other groups including the public. Let us be active and not inert, leaders, not followers.

A Book Review of:

"The Serpent-Wreathed Staff" by Alice Tisdale Hobart

Editor's Note: Ordinarily we do not comment on modern novels in the Journal. Yet, when the author of a number of best sellers, a woman of outstanding ability as a writer, employs her art in such a fashion as to undermine the medical profession and present a subtle case for socialized medicine, we feel the matter is of sufficient importance to our readers to call it to their attention in this way.

If Mrs. Alice Tisdale Hobart had managed to devise a suitable ending for her 402-page novel, "The Serpent-Wreathed Staff," about sixty pages sooner than she did, a tolerant critic would be able to say that she had written a faulty but highly interesting story of human conflicts and loyalties.

Unfortunately, however, the latter part of the book degenerates swiftly and recklessly into an amazing propaganda piece for National Compulsory Health Insurance. The last forty or fifty pages sound as if Mrs. Hobart knocked them out hastily at a desk piled high with pamphlets, speeches and news releases handed out by Federal Security Administrator Oscar Ewing and the Committee for the Nation's Health.

This uncraftsmanlike abuse of artistic license, added to some of the implications built up in earlier pages, creates the impression that the entire novel was designed as a subtle presentation of the case for Socialized Medicine. As a result, Mrs. Hobart undermines much of the validity that does exist in some of the earlier parts of this book about doctors, modern medicine and a changing world.

Despite her failure to give a true interpretation of the social and economic developments in medicine today, the author shows her usual skill in weaving a plot and telling a story. She is at her best when describing the personal problems and struggles, the emotional triumphs and defeats, of her principal characters. On this fictional level the book has undeniable merit and strength, for the reader finds himself sharing the fears, anxieties and grief of the people in the novel.

Central figures in the story are two brothers, Dr. Alan Towne and Dr. Sam Towne, grandsons of old Dr. Samuel Towne, who had achieved medical eminence only after many years of struggle and criticism because of his unorthodox

ideas. Sam, the older of the two brothers, is portrayed as successful, wealthy, conservative. Alan is drawn as the idealistic, progressive pioneer, striking out in new and dangerous directions and carrying on in the tradition of his grandfather.

Main action of the novel begins shortly after the end of World War II when Alan leaves a comfortable, assured partnership with Sam to start a group practice. From then on the troubles and tragedies mount in rapid sequence and growing complexity. In the short space of three or four years Alan becomes an "Anthony Adverse" in modern American medicine.

When the facile, all-inclusive plot is used as a mechanism for discussion of the social, economic and political aspects of modern medicine, the book suffers not only from the standpoint of literary merit but also from the standpoint of accurate reporting. On this level the book is dangerously superficial. Complex problems and issues affecting the practice of medicine are introduced in rapid-fire, hop-skip-and-jump fashion — over-simplified and over-dramatized, but mixed with just enough truth and half-truth to give credence to a distorted picture.

As all of these elements are woven deftly into the novel, their manner of presentation builds the subtle implication—even in the earlier parts of the book—that most doctors are primarily and selfishly interested in making money, bolstering their own reputations and preserving the status quo in medicine.

Mrs. Hobart also gives the impression that group practice, health insurance plans, preventive medicine and similar ideas are brand new developments—practically untried and unheard of in a present-day American city. Actually, most of the concepts and projects which occur to Alan Towne, in sudden flashes of inspiration, are part of the knowledge of any alert medical student. Actually, the industrialists and business men on Alan's hospital board are utterly untypical when they talk and act as if they had never heard of such a thing as group health insurance for their employees.

Before Mrs. Hobart writes another novel on this subject, someone should familiarize her with the major facts and realities in

the field of modern medical economics.

Someone, for example, should tell her about the many famous clinics and countless other form of group practice which are in successful operation throughout the country, some of them since around the turn of the century.

Someone should tell her about the hundreds of fast-growing, constantly-improving Voluntary Health Insurance plans, which by the end of this year will be protecting an estimated 90 million Americans against the major costs of illness and accidents.

Someone should tell her about the Nationwide progress of State and County Medical Societies in setting up doctor placement programs, grievance committees, emergency call systems, cost adjustment committees, local health units and a variety of other activities designed to make good medical care available to all the people.

Incidentally, someone also should inform Mrs. Hobart that the "National Medical Association," a name which she uses as a pseudonym for the American Medical Association, is the actual and proper name of the National organization

of Negro physicians.

But Mrs. Hobart, unmindful of such trivia as facts and accuracy, writes furiously on, and after only two or three years of struggle in group practice and as head of a group hospital, Dr. Alan Towne is an advocate of Government Health Insurance. Apparently neither the author nor the good young doctor sees the glaring contradiction between Government medicine and Alan's own philosophy of careful, personalized treatment of the whole patient, in mind and spirit as well as in body.

Everyone interested in American medicine, and in the effort to find intelligent solutions to our medical care problems, should read "The Serpent-Wreathed Staff"—if for no other reason than to help repair the damage which the book does.

Read simply as a novel, it is a moving, absorbing story.

Read as a source of information affecting public opinion on medical-economic issues, it unfortunately is an example of careless, superficial writing, with a built-in conclusion contrary to the convictions of the great majority of Americans today.

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WHY THE RURAL HEALTH EFFORT?

Why has the Council of the K.S.M.A. endorsed, supported and encouraged the efforts of the Committee on Rural Health of the Association to develop and establish a statewide Rural Health Council in Kentucky?

Because the Council feels such an organization provides the ideal vehicle to bring about a greater degree of mutual understanding between members of the medical profession and residents of rural areas on matters relating to the community health. Coordination and cooperation between farmers and physicians through local rural health councils has been developed in a large number of states, several bordering Kentucky, in a way never before thought possible.

Everyone is interested in health. Most everyone wants to do something about it. Practically every large statewide lay organization has health committees at the state and component level. Some of the

larger groups are The Kentucky Farm Bureau Federation, The Kentucky Parent-Teacher Association and The American Legion.

These well-intentioned groups have high ideals and worthy objectives and a will to perform. The thing they need most—and often get the least—is physician leadership, consultation and cooperation. They will welcome professional help, advice and direction. It is up to the medical profession to recognize this. It gives the physician a golden opportunity to render an unselfish assistance and to provide efficient direction to these worthy endeavors of lay groups.

Community health is a community responsibility. While medical care is an essential and important part of the picture, community health goes far beyond medical care. Other elements include sanitation, hospital and nursing facilities, immunization, proper diet, health education,

school health, avoiding farm hazards and promotion of voluntary medical care and hospital insurance.

The obligation of the local physician transcends the mere rendition of medical service. As the President of the Medical Society of Virginia recently commented when he was in Louisville, "No doctor is in private practice—it is a public service he renders." For the sake of the patients

we serve—and for the sake of the profession that has been good to us—let us recognize our responsibility and discharge our obligations. If we do not do this now then we have no one to blame but ourselves for development in the future that will be highly objectionable to those who subscribe to the American Way of Life.

Walter L. O'Nan, M. D., Chairman
Committee on Rural Health

PROFITABLE TEAMWORK

One of the most substantial compliments a publication can receive is to have such attractive issues that more organizations wish to advertise their products or services in it.

For the past three years the staff of your Journal has vigorously sought to improve the appearance and scientific and organizational content. We have been gratified to receive commendation from sources both in and out of the state.

While we are greatly pleased that our volume of advertising has shown an increase, we are reminded that the cost of publishing good medical literature has increased substantially.

Our advertisers have not escaped the added cost of doing business. Their operating expenses are up proportionately and their taxes have been increased.

The revenue from sale of space to advertisers in our journal pays the major portion of the cost of publishing it. Our advertisers, therefore, are making a major contribution to medical education in Kentucky.

As long as we have a good journal that is read and as long as our advertisers are getting value received, we will have revenue to continue to give you a worthwhile publication.

Our advertisers are of the most trustworthy available. Their products are tested and approved—they operate on an ethical basis.

We urge you to read our ads and patronize our advertisers. Your cooperation will operate to your advantage. Our advertisers are worthy of your support.

WHAT YOU SHOULD KNOW ABOUT BIOLOGICAL WARFARE

The National Civil Defense Administration has released a pamphlet "What You Should Know About Biological Warfare." Its purpose is to inform the public concerning the threat and limitations of biological warfare and what should be done in the face of danger.

This statement is included: "Biological attacks could be made by enemy forces or by secret agents. The attacks could be aimed at people, animals or food crops. But - - biological warfare is no secret super weapon. There are defenses against it and you should know what they are. Biological warfare is simply a special kind of attack. It could not wipe out a whole nation or even a city. If we all work together, we can meet any biological warfare attack."

Bacteriologists are not in agreement

concerning the probable effectiveness of Biological warfare. Micro-organisms suitable for such use may be guessed at by anyone with some knowledge of bacteriology. The enemy would probably not use an organism against which a large segment of the population is immunized. He would prefer that it not be susceptible to treatment with antibiotics.

A short incubation period would be desirable and the condition produced should be highly contagious. The disease produced should not be endemic in the area in which it is to be used, particularly if immunity is gained by infection. Some biological warfare students have estimated that fewer than ten organisms meet these and other related considerations. Your guess is as good as anyone's.

ORGANIZATION SECTION

First Statewide Rural Health Conference To Be In Louisville May 7 & 8

K. S. M. A. And Co-Sponsors To Present Nationally Prominent Speakers At Brown Hotel

Nationally prominent leaders will be featured May 7 and 8 on the first statewide Rural Health Conference, which will be sponsored by the Kentucky State Medical Association and twelve other statewide organizations, in the Roof Garden of the Brown Hotel, Louisville.

Walter L. O'Nan, M. D., Henderson, Chairman of the K.S.M.A. Committee on Rural Health and the State Rural Health Council, made the announcement immediately after the Council met in the Headquarters Office March 13 and completed arrangements for the Conference.

"All members of county medical society rural health committees are urged to mark these dates and plan to attend. All other county societies are asked to see that at least one member of their organization be present at this important conference. The Rural Health Council is heartily endorsed by both the A.M.A. and our own association. It is one of the most worthwhile efforts the K.S.M.A. has made," Dr. O'Nan said.

Highlights of the program that will start at 2:00 P. M., Wednesday, May 7, include a talk by F. S. Crockett, M. D., Lafayette, Indiana, Chairman of the A.M.A. Council on Rural Health, co-founder of the rural health movement with Mrs. Charles W. Sewell of Otterbein, Indiana, also nationally known in farm organization activities, who will be the speaker at the dinner meeting.

Aubrey Gates, Field Director of the A.M.A. Council on Rural Health, will be featured along with Sewall Milliken, Chief of Public Health Education Division, Ohio State Department of Health, and Frank Welch, new Dean of the College of Agriculture of the University of Kentucky. The Kentucky State Dental Association will also provide a speaker of national ranking.

Clark Bailey, M. D., Harlan, K.S.M.A. President, will give the address of welcome; Clyde C. Sparks, M. D., Ashland, Chairman of the Council, will moderate the last session Thurs-

day morning, May 8; and R. Haynes Barr, M. D., Owensboro, K.S.M.A. President-Elect, will give the closing address. Dr. O'Nan will moderate the first session Wednesday afternoon.

"We Have Waited Long Enough" will be the theme of the Conference. Tentative program for the meeting appears below.

Co-sponsoring organizations for the first statewide Conference are: Extension Service, University of Kentucky; Division of Child Welfare, Department of Economic Security; Division of Vocational Education, Department of Education; Kentucky Congress of Parents and Teachers; Kentucky Farm Bureau Federation; Kentucky Hospital Association; Kentucky Pharmaceutical Association; Kentucky State Association of Registered Nurses; Kentucky State Dental Association; Kentucky State Department of Health; University of Louisville School of Medicine; and Woman's Auxiliary to the K.S.M.A.

PROGRAM:

The First Statewide Rural Health Conference in Kentucky, will be held at the Roof Garden of the Brown Hotel, Louisville, Wednesday and Thursday, May 7 and 8, 1952.

AFTERNOON SESSION, 2 P. M., Wednesday, May 7, Walter L. O'Nan, M. D., Henderson, Chairman of the K.S.M.A. Committee on Rural Health, presiding.

Welcome—Clark Bailey, M. D., Harlan, President, Kentucky State Medical Association.

"Are We Still '47?," Mr. James Armstrong, Henderson.

"Health Begins At Home," Miss Myrtle Welton, State Leader, Home Demonstration Agents, Extension Service.

Kentucky State Dental Association to provide speaker, nationally known member of the A.D.A.

"Health and the Farm Organization," Mrs. Tom Dulin, Chairman, Health Committee of the Kentucky Farm Bureau Federation.

"The Meaning of a Rural Health Program," Aubrey Gates, Field Director, A.M.A. Council on Rural Health.

"Who Is Going To Do It?," a skit to be supervised by D. G. Miller, Jr., M. D., Morgantown, Member of A.M.A. Council on Rural Health.

EVENING SESSION, 6:30 P. M.

Dinner, Toastmaster, J. E. Stanford, St. Mat-

thews, Executive Secretary, Kentucky Farm Bureau Federation.

F. S. Crockett, M. D., Lafayette, Indiana, Chairman of the A.M.A. Council on Rural Health.

Mrs. Charles W. Sewell, Past President of the American Farm Bureau Federation Women's Organization.

MORNING SESSION, 9 A. M., Thursday, May 8, Clyde C. Sparks, M. D., Ashland. Chairman of the Council of the Kentucky State Medical Association, presiding.

"Health Conservation," Dean Frank Welch, College of Agriculture, University of Kentucky.

"Problems of the Rural Health Doctor," D. G. Miller, M. D., Member of A.M.A. Rural Health Council.

"Health is the Community's Business," Raymond F. Dixon, Executive Officer, State Department of Health.

"Why a County Rural Health Council," Sewall Milliken, Chief of Public Health Education Division, Ohio State Department of Health.

"Following Through Back Home," R. Haynes Barr, M. D., Owensboro, President-Elect of the Kentucky State Medical Association.

Delinquent Members To Lose Benefits After April 1

If you have not already paid your 1951 county and state dues, you are urged by the Council to do so at your earliest convenience. April 1 has been set by the Council as the deadline. If you do not remit your membership fees:

1. You will lose your subscription to the Journal beginning with the May 1952 issue.
2. Your malpractice defense provided by the Association will be discontinued.
3. Jeopardize your malpractice insurance coverage. Some companies discontinue coverage at the time medical society membership expires.
4. Withdraw your support from organized professional activity.
5. Weaken the fight against compulsory health insurance.

Dr. Bailey Appointed To Legislative Committee Of AMA

Clark Bailey, M. D., Harlan, K.S.M.A. President, has been appointed to serve on the American Medical Association Committee on Legislation, according to an announcement by

George F. Lull, M. D., Secretary and General Manager of the A.M.A.

Dr. Bailey, who was a K.S.M.A. Delegate to the A.M.A. from 1944 until he resigned to become K.S.M.A. President-Elect in October 1950, will succeed the late Oscar B. Hunter, M. D., Washington. Dr. Hunter was a Vice-President of the A.M.A., having been elected in 1951 at Atlantic City.

This A.M.A. group considers all legislation that concerns the health of the nation, which is introduced into Congress, and makes a recommendation to the Board of Trustees on what the A.M.A.'s stand should be.

Ky. Surgical Soc. To Hear Dr. Cave May 24 At French Lick

Henry W. Cave, M. D., New York, will be the guest speaker at the Third Annual Meeting of the Kentucky Surgical Society, Saturday, May 24, at French Lick, Indiana, Francis Massie, M. D., Lexington, Secretary of the Society, has announced.

The scientific program will start at 1 P. M. Most of the members and guests will arrive Friday afternoon and remain over Sunday, Dr. Massie said. Wives of the members and guests are invited.

"Management of Massive Hemorrhage from Upper Gastrointestinal Tract" will be discussed by Dr. Cave, who is a native of Paducah.

In addition to Dr. Cave, the program will include: "Complications of Gallbladder Surgery," J. Duffy Hancock, M. D., Louisville; "Small Bowel Tumors," A. E. Grimes, M. D., Lexington; "Urinary Incontinence in the Female," Robert Lich, M. D., Louisville; "Considerations of Surgical Treatment of Carcinoma of the Cervix," Laman A. Gray, M. D., Louisville.

A.A.G.P. President, Secretary To Speak To State Group

Plans for the April 30 meeting of the Kentucky Academy of General Practice have been completed, Richard R. Slucher, M. D., President, stated.

Featured speakers on the program are R. B. Robins, M. D., Camden, Arkansas, President, A.A.G.P.; Phil Thorek, M. D., Chicago; Joseph G. Crotty, M. D., Cincinnati; Bernard Weinstein, M. D., New Orleans; Mac F. Cahal, Kansas City, Missouri, Executive Secretary, A.A.G.P.; Robert Lich, M. D., Louisville; and Alex J. Steigman, M. D., Louisville.

The March Journal of the K.S.M.A. carried the full program.



Panelists for the first Telephone Seminar presented February 26 are left to right: William M. Christopherson, M. D., Assistant Professor of Pathology; Walter S. Coe, M. D., Assistant Professor of Medicine, Moderator; J. Murray Kinsman, M. D., Dean, University of Louisville School of Medicine, who introduced the panel; Marion F. Beard, M. D., Associate Professor of Medicine, Chief of Hematology Section; George B. Sanders, M. D., Assistant Professor of Surgery.

Listening M. D.'s Praise Quality Of Telephone Broadcast

The many messages and letters received from the physicians in the listening counties after the first telephone P. G. broadcast February 26, all expressed unanimous appreciation and most of the men felt the Seminar was highly successful, Robert L. Lich, M. D., Louisville, Chairman of the Committee on Medical Education, reported.

There were 25 outlets for the first broadcast and physicians from one to four counties listened at each point of reception. It was estimated that the February 26 audience was the largest ever to hear a medical program in Kentucky.

One listening physician said, "The material presented showed a great amount of preparation on the part of those who participated in the panel." This statement coincides with a comment one of the panelists, a veteran in presenting medical papers, made just before the broadcast started, "I worked five times as hard on this thing as on any paper I ever gave. I surely hope it goes over."

Dr. Lich and Herbert L. Clay, M. D., Louisville, director of postgraduate training at the Medical School, who arranged the program, went to Lebanon to hear the first broadcast. Physicians from Taylor and Washington Counties were also present at the Marion County outlet.

Since the first Seminar which dealt with "Management of the Patient With Jaundice" two additional counties, Pike and Morgan, asked for the second Seminar, March 18, which dealt with "Office Gynecology." The original list of participating counties were: Bell, Boyle, Calloway, Carter, Clay, Clinton, Fulton, Garrard, Grant, Harlan, Henderson, Hopkins, Letcher, McCracken, Madison, Marion, Mason, Montgomery, Muhlenberg, Pulaski, Shelby-Oldham, Union, Warren, Wayne and Whitley.

The magazine section of the March 16 Sunday Courier-Journal carried a feature story on the first seminar. The article covered all phases of the undertaking and included pictures of the panelists, of the doctors from Shelby, Oldham and Henry Counties listening at Shelbyville, and a map showing the pattern of the telephone circuits used for the Seminar.

Chest M. D.'s To Meet June 5-8

The American College of Chest Physicians will hold its Eighteenth Annual Meeting at the Congress Hotel, Chicago, June 5-8, 1952. T. Ashby Woodson, M. D., Louisville, Governor of the College for Kentucky, announced.

The Board of Examiners of the College announces that the next oral and written examinations for Fellowship will be held in Chicago June 5, 1952. Those wishing further information should contact: Executive Secretary, American College of Chest Physicians, 112 East Chestnut Street, Chicago 11, Illinois.

Officers of the Kentucky Chapter of the College are: Hugh L. Houston, M. D., Murray, President; E. R. Gernert, M. D., Louisville, Vice-President; Lawrence A. Taugher, M. D., Louisville, Secretary-Treasurer. John S. Harter, M. D., Louisville, is Second Vice-President of the Southern Chapter of the College.

Members Urged To Make Nominations For KSMA Annual Awards

Members of K.S.M.A. are urged to be thinking about their nominations for the annual awards. Either an individual or county society may submit nominations for any of the three awards to the Headquarters Office.

The awards and their requirements are:

The Distinguished Service Medal—Awarded on the basis of the following points: (1) Contribution to organized medicine (including membership in county society, attendance county and state, service on committees, as an officer, etc.) (2) Individual medical service, (3) Community health education and civic betterment, (4) Medical research, (5) Medical teaching, (6) Active military service. The applicant may qualify on any one, all or any combination of these points. Reasons for the nomination should be clearly stated.

E. M. Howard Award—Given for outstanding service rendered in behalf of organized medicine.

J. Watts Stovall Award—Conferred on the general practitioner adjudged the most outstanding in the state.

Surgical Congress Hears Kentuckians

The Southeastern Surgical Congress convened March 10, 11, 12, and 13, 1952, at the Atlanta Biltmore Hotel, Atlanta, Georgia. Three members of the Kentucky State Medical Association participated in the program.

Francis M. Massie, M. D., Lexington, spoke on the subject "Complication of Surgery for Duodenal Ulcer." The other Kentucky speakers were: J. Farra Van Meter, M. D., Lexington, "Cyst of the Pancreas, Further Observations on Treatment by Internal Drainage," and David M. Cox, M. D., Louisville, "Post Partum Care of Patients."

Tri-City Ob.-Gyn. Meet Feb. 25

The Tri-City meeting of the Cincinnati, Indianapolis, and Louisville Obstetrical and Gynecological Societies was held February 25, with the Louisville Society as host. Approximately 75 guests and members were present from the three societies.

W. O. Johnson, M. D., Laman A. Gray, M. D., and Silas H. Starr, M. D., all of Louisville, discussed Operative Procedures at the morning session. In the afternoon, Obstetrical and Gynecological subjects were discussed.

The gathering was climaxed by a dinner and scientific paper at the Roof Garden of the Brown Hotel. Lawrence M. Randall, M. D., Mayo Clinic, Rochester, Minnesota, was the guest speaker for the evening.

M. D.'s Planning Scientific Exhibit Must Request Forms

A well-balanced and profitable display is planned for the Annual Meeting at the Columbia Auditorium in Louisville, October 7, 8, and 9, Everett L. Pirkey, M. D., Louisville, Chairman of the Committee on Scientific Exhibits, stated following the first meeting of his group.

"We have already received a number of requests for space at the 1952 Annual Meeting. Application forms have been prepared and we urge all physicians interested in presenting an exhibit to write for the blanks on which official application is made and a description of their proposed exhibit. We ask this because our space is limited and we want to take care of our members first," Dr. Pirkey said.

Those wishing forms should write to Dr. Pirkey at 323 East Chestnut Street, Louisville. The deadline for returning the application will be August 1.

Induction Of 485 Priority I M. D.'s Delayed Until May

The induction of 485 physicians in Priority I, originally scheduled for August and September in 1951 has been postponed until May by the Selective Service System at the request of

the Department of Defense.

This delay grows out of the fact that there are sufficient numbers of physicians in Priority I in the Reserve to meet military requirements for active duty. It was emphasized by a recent Defense Department release, however, that if there should not be enough registrants volunteering for the reserve, it will be necessary to make up the call through induction.

Priority I medical registrants are those who participated as students in the Army Specialized Training Program administered by the Navy, and those persons who were deferred from service during World War II to attend medical school and who have served less than 90 days in the Armed Forces, the Coast Guard, or the United States Public Health Service subsequent to the completion of or release from the programs or courses of instruction.

Largest Private Channel Brings Seminar To Local Counties

The February 23 Telephone Seminar Broadcast was the largest private "channel" that has ever been set up in Kentucky by the Southern Bell Telephone system and cooperating companies, Mr. Joseph Mitchell, Southern Bell representative, who handled the arrangements for the broadcast with the Headquarters Office, said.

Many officials of the company manifested a keen interest in the broadcast in which not a single technical failure was reported. Weeks of planning by company technicians were a part of the preparations for the 25 county outlet.

Circuits for the network were set up in some cases hours before the broadcast, in order that they could be properly tested. Programs of one of the national radio chains were fed out over the network during the day of the broadcast as sound technicians and local phone company workers made final arrangements for seminar reception.

Doctors' Day Set For April 13

Plans for the celebration of Doctors' Day April 13, by the Women's Auxiliary to the Kentucky State Medical Association will be sponsored by the local organization in each county, Mrs. John S. Harter, Louisville, President, announced.

Thomas Walker, M. D., entered Kentucky from Virginia on this date in 1750 and Doctors' Day this year will commemorate this event, Mrs. Harter said.

Pertinent Paragraphs

A report by the A.M.A. Council on Medical Service shows that rapid strides are being made on developing emergency call systems, but there is still need for more work on the problems especially among the smaller medical societies. In 1948, only about 60 medical societies reported having a formal plan for handling emergency and night calls; by 1950 the number had risen to more than 350.

A study of static electricity in hospital operating rooms made by three U. S. Bureau of Mines scientists, has led to the fact that "there is probably no combination of equipment and personnel activity anywhere more liable to produce casual, dangerous charges of electricity than that found at present in the anesthetizing areas of most hospitals." The report cites that over the years, few hospitals have made a deliberate and persistent effort to apply suggested remedies effectively.

The American Medical Association has requested the Senate Armed Services Committee to consider amending Universal Military training legislation allowing pre-medical and medical students to be deferred from serving 7½ years in the reserve, once their basic 6-months training is over, until they have completed their professional training.

The Second Annual Medical Seminar of Mount Sinai Hospital of Greater Miami will be held May 22, 23 and 24 at the Delano Hotel, Miami Beach, Florida, on the subject, "Recent Advances in Diagnosis and Treatment." Those desiring further information should write to: Chairman, Seminar Committee, Mount Sinai Hospital, 4300 Alton Road, Miami Beach, Florida.

Two postgraduate courses will be presented by the Michael Reese Hospital Postgraduate School, Chicago, during May, 1952. A two-week course in "Recent Advances in Internal Medicine," will be offered from May 12th to May 24th. This course encompasses a systematic review of recent advances in the various branches of internal medicine. "Recent Advances in Pediatrics—Diagnostic and Therapeutic Measures," will be offered as a one week course from May 26th to May 31st. For further information, address: Dr. Samuel Soskin, Dean, 29th Street and Ellis Avenue, Chicago 16, Illinois.

The Council of the Illinois State Medical Society voted for the third year to send TO-DAY'S HEALTH, published by the American Medical Association, to all members of the Illinois State Legislature, and the Federal Legislature from Illinois. The arrival of this magazine each month is a reminder to the legislator of the doctors' interest in him, the ISMA announcement said.

The Christian County Medical Society of Illinois is the first county medical society in that state to make a per capita contribution to the Medical Education Foundation.

The International Conference on Vitamins and Metabolism was held in Havana, Cuba, late in January. Elmer L. Henderson, M. D., Louisville, participated in the program.

The Women's Auxiliary to the Kentucky State Medical Association is planning a state wide radio campaign to study health problems in Kentucky schools. The auxiliary has worked for several years to improve health conditions in the state's 3,000 one-room schools.

Volume 1, Number 1, of the Maryland State Medical Journal made its bow in January of this year. The staff of the Journal of the Kentucky State Medical Association extends its congratulations and best wishes to this attractive new publication of the Medical and Chirurgical Faculty of the State of Maryland.

The local medical and dental groups of Paris have fully approved the proposed plan for the fluoridation of the public water supplies. The purpose of the plan is to help reduce tooth decay, with the greatest benefits to the child who drinks such water from birth.

The conference of State and Territorial Health Officers strongly endorsed legislation for federal aid in developing local public health units. Another resolution stated that the association offered its cooperation to AMA, Amer. Hospital Association, and Amer. College of Surgeons, and recommended that every state agency concerned with hospital licensure or construction do the same.

The Board of Trustees of the A.M.A. has recommended a \$10,000 appropriation for the 1952 student nurses recruitment program of the Committee on Careers in Nursing, following the recommendation of the finance committee, the Chicago office has announced. The supply of nurses for essential civilian needs is short, and the shortage is aggravated by heavy military requirements.

George Bond, M. D., Bat Cave, North Carolina, has just completed 19,000 miles attending rural health conferences in this country. Dr. Bond believes that community health is a community responsibility and that the medical profession should take the leadership in working with lay groups in solving the community problems.

The Illinois and Eastern Iowa district of Kiwanis International will undertake a \$75,000, 5-year research program on the spastic paralysis child, Harry S. Himmel, Chicago, chairman of the district's spastic child committee, has announced. The money will be raised at the rate of \$15,000 a year by voluntary contributions from the more than 10,000 members in 171 clubs in Illinois and Eastern Iowa, he said.

Mr. Aubrey Gates, Director of the Extension Service of the University of Arkansas, Little Rock, has permanently joined the staff of the A.M.A. Council on Rural Health as Field Director. Mr. Gates, who has rendered the K.S.M.A. Rural Health Committee such excellent service, was "loaned" to the A.M.A. by the University for a 15-month period ending last summer. We all welcome Mr. Gates back into the family.

With the tourist season at hand, you and your family or some of your patients may have planned a foreign trip, and you will be called upon to administer the list of vaccinations required of travelers heading for a foreign country. You may secure this list from: The Pan American Sanitary Bureau, The Regional Office of World Health Organization, 1501 New Hampshire Avenue, N. W., Washington 6, D.C. Vaccinations most generally required are against smallpox, yellow fever, and cholera, with some countries insisting on inoculation against typhoid and paratyphoid fevers, typhus, diphtheria and tetanus.

President's Page

During the last few months, the Committee on Rural Health of the Kentucky State Medical Association with Dr. Walter L. O'Nan of Henderson, Kentucky, as Chairman, has been most active in its organizational work. Patterned after the Rural Health Committee of the American Medical Association organized seven years ago primarily to try to interest more physicians in rural practice but whose larger purpose has come to be the consideration of all problems of rural health in America, the Committee has had meetings with representatives of interested groups who are deeply concerned about rural health. Since seventy per cent of the population of the state of Kentucky is defined as rural, the magnitude of this problem can readily be seen.

The Committee on Rural Health of the Kentucky State Medical Association, with the approval of the Council, has recently organized a Council on Rural Health. The philosophy of the members of this Council, the same as that of the parent Council of the American Medical Association, has had from the first the goal of encouraging farm persons to help themselves. "They always have envisioned the role of their Council as that of a coordinator, who interests communities in their own health problems, encourages the persons in the community to work together to solve these problems, and then passes along the experience and the good ideas thus gained to others in need of help."

Dr. O'Nan has just returned from the Seventh National Conference on Rural Health held at Denver, Colorado. The first state-wide Rural Health Conference will be held in Louisville, Wednesday and Thursday, May 7 and 8. The Conference will be sponsored by the Kentucky State

Medical Association and co-sponsored by the following groups:

Cooperative Extension Work in Agriculture and Home Economics, U. of K.

Division of Child Welfare, Department of Economic Security, State of Ky.

Division of Vocational Education, Department of Education, State of Ky.

Kentucky Congress of Parents and Teachers

Kentucky Farm Bureau Federation

Kentucky Hospital Association

Kentucky Pharmaceutical Association

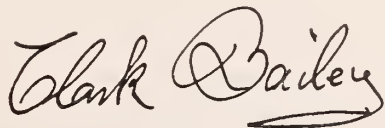
Kentucky State Association of Registered Nurses

Kentucky State Dental Association

Kentucky State Department of Health

University of Louisville School of Medicine

This Conference will serve as another milestone in the progress Kentucky doctors have made cooperating with the people they serve in studying together problems of health. We are fortunate indeed as members of the medical profession to have the opportunity of studying rural health problems with the farm groups and other interested civic organizations so that together, in a spirit of freedom, we might find a solution to many of these problems in the truly American way. May I encourage each of you, both on the state and local levels, to work with these Councils and give them the benefit of your guidance.



PRESIDENT

County Society Reports

CAMPBELL-KENTON

The January meeting of the Campbell-Kenton County Medical Society was held at Glenn Schmidt's Playtorium on Thursday evening, January 17, 1952. After the dinner the meeting was called to order by Dr. George Riley, in the absence of the President, Dr. Walker Air. Dr. Riley introduced Miss Ann Bruegger to the Society, as the Executive Secretary. Dr. Air's message to the Society was read. He announced the appointment of the Public Relations and Legislative Committees.

The minutes of the previous meeting were read and approved.

Dr. Schultz recommended that the State delegates that had been elected in 1951 be reappointed for 1952. The delegates had previously been elected each year, and in so doing there was confusion as to their duties and responsibilities in the State meeting. The motion was made that Drs. Pierce, Frickman, Walsh and Bach be named as delegates, and that Drs. Adair, Temple, Reik, and DeVillez be named as Alternates. Dr. Kumpe seconded the motion. By counting of hands the motion was passed.

The out-going President, Dr. Reichert, thanked the committees and members for their cooperation during the past year. He proposed two items for the Society to consider: 1. That the dues of the society be raised from \$5.00 to \$10.00 per year. Dr. Walsh made this motion and it was seconded by Dr. Weber. Motion was passed. 2. That the Executive Secretary's salary be raised from \$15.00 to \$30.00 a month. This motion was made by Dr. Walsh and seconded by Dr. Stratman. Motion was passed.

Dr. Hiltz gave the report on the Board of Censors in reference to the application of Dr. Phillip Katz. The entire committee recommended the acceptance of Dr. Katz to the Society. A vote by secret ballot resulted in the election of Dr. Katz to membership.

Dr. Edward Stratman gave a short talk on the Red Cross mobile blood unit, and urged the doctors to cooperate.

The emergency medical service was presented for discussion by Dr. Pierce, who suggested that a list of all the doctors be given to the Academy of Medicine, so that the operators could handle this service in Northern Kentucky. Discussion followed by Drs. Robinson, Stewart, Biltz, Schultz, J. Molony, Haizlip and H. Zwick. Dr. Pierce was empowered to work out a plan that would include the communities involved as suggested by Dr. Zwick, so that

some concrete master plan would facilitate the handling of emergency calls.

Dr. Mel Weber introduced Mr. O'Connor, who showed an interesting movie, "Travelogue." Meeting adjourned at 10:15 p. m.

Norman Adair, M. D., Secretary

CAMPBELL-KENTON

The February meeting of the Campbell-Kenton County Medical Society was held at St. Elizabeth Hospital. The meeting was called to order by the President, Dr. Walker Air. The minutes of the previous meeting were read and approved. Dr. Humpert introduced the guest speaker, Dr. George Hayden, who gave an interesting talk on "Endometriosis."

On motion of Dr. Stratman and seconded by Dr. Hoffman, the medical society approved the increase in fees of nurses in Campbell and Kenton Counties. This communication was passed on directly to the nursing society.

Old Business: Dr. Air stated that any new business should be submitted to the Executive Council for consideration and discussion with the Reference Committee, but that all final decisions would be left to the vote of the Society.

Dr. Air sent telegrams to the local Senators and Representatives asking their support of Hospital Bill No. 50.

Dr. Pierce reported the activities of the Legislative Committee, and its visit to the local Chamber of Commerce where the Hospital Bill was discussed with Senator Wagner, Representatives Ruh, Jonas, and Dressman. The Legislative Committee advises each member to contact his Representative to ask that they support the different pieces of legislation which have been endorsed by the State Medical Society.

Dr. Schultz reported that 70 members are now utilizing the facilities of the Physicians Exchange in cooperation with the Cincinnati Academy of Medicine.

The President of the State Medical Society will speak November 6th, which will not conflict with the Southern Medical Meeting which is being held November 10th to 13th.

On motion of Dr. Schultz and seconded by Dr. Miner, a letter of appreciation was to be mailed to the Women's Auxiliary, congratulating them on their excellent job of bringing forth information regarding Socialized Medicine to different social groups.

The Society felt that we should not have the Cancer Mobile Diagnostic Clinic in this area as

there is an active Cancer Clinic present at Booth Memorial Hospital.

The application of Dr. Anthony Giglia for membership to the Society was read for the first time and was referred to the Board of Censors.

New Business: Dr. Reichert stated that Civilian Defense Committee now has \$4,500.00, and will become active.

It was brought to the attention of the Society that 49 members returned their Historical Sheets and the others are urged to complete theirs and return immediately.

Dr. Molony brought to the attention of the Society the different types of insurance protection programs that are available. Drs. Molony, Cassidy and Hoffman were asked to discuss this problem with insurance representatives.

Dr. Adair reported that the State Legislative Committee discussed 36 bills which are to appear before the State Legislation. He also made a trip to Frankfort and asked support of our Representatives and Senators for the Hospital Bill No. 50.

The meeting adjourned at 11:20 p. m.

Norman Adair, M. D., Secretary

CALDWELL

At a meeting of the Caldwell County Medical Society, held in connection with a dinner meeting of the Four County Medico-Dental Society in Princeton, February 29, the following officers were elected for the current year: Dr. Kenneth L. Barnes, President; Dr. Ralph L. Cash, Vice-President; Dr. John E. Cotthoff, Secretary, succeeding Dr. W. L. Cash, who has served as the Society's secretary for over thirty years; Dr. Frank P. Giannini, Delegate to the State Association; Dr. Frank T. Linton, Alternate Delegate.

The following program was given: "Prolonged Labor," Dr. S. Starr, Clinical Professor and Chief of Obstetrics, University of Louisville; "Treatment of Fractures in Small Hospitals," Dr. John E. Haynes, Dawson Springs; "Feeding and Care of Infants Under 1 Year of Age," Dr. Henry Work, Professor of Pediatrics and Mental Hygiene, University of Louisville.

W. L. Cash, M. D., Secretary

FAYETTE

The regular meeting of the Fayette County Medical Society was held in the Good Samaritan Hospital Auditorium on January 8, 1952. The meeting was called to order by the president, Dr. W. H. Pennington. The minutes of

the previous meeting were read and approved. The new president, Dr. R. G. Elliott, was escorted to the chair by Dr. E. L. Moore. The secretary retired and released his chair. The paper of the evening was a report of recent experimental studies on pain and analgesia by Dr. Abraham Wikler and was discussed by Dr. Matthew Darnell.

Application of Dr. Louis Hamons, Jr., having been approved by the Board of Censors was voted upon and he was elected to membership unanimously. Dr. Edward Rankin presented a committee report on study of the local medical care for emergency cases. The report was discussed by Dr. John Scott, Dr. Allen Cornish, Dr. E. L. Moore, Dr. Tom Marks, Dr. Irving Kanner, Dr. James Stith, Dr. Caroline Scott, Dr. R. J. Griffin, Dr. W. H. Pennington, and Dr. E. S. Maxwell.

The application of Dr. Thompson Bryant, Jr., for membership in the Society was read and the application turned over to the Board of Censors. A letter from Mr. Leroy Miles representing the American Red Cross Chapter was read by the president concerning a visit of the Blood Mobile to Lexington in February. This was unanimously endorsed by the Society after discussion by Dr. John Scott, Dr. William Pennington, Dr. Farra Van Meter, Dr. James McClellan, Dr. Irving Kanner, Dr. Coleman Johnston, Dr. Sam Warren and Dr. Matthew Darnell.

John B. Floyd, Jr., M. D., Secretary

JOHNSON

At the meeting of the Johnson County Medical Society March 6, 1952, the following officers were elected:

John Turner, M. D., Paintsville, President; Charles L. Preston, M. D., Paintsville, Vice-President; Augustus D. Sloane, M. D., Paintsville, Secretary-Treasurer.

The regular meeting night was changed from the last Thursday in the month to the last Tuesday in the month.

Augustus D. Sloane, M. D., Secretary

JEFFERSON

The Annual meeting of the Jefferson County Medical Society was held January 21, 1952 at the Seelbach Hotel. There were 118 members present for dinner and about 15 additional for the business meeting.

The meeting was called to order at 8 p. m. by the President, Dr. Lytle Atherton.

Ballots for the election of 1952 officers were distributed by the tellers. There being no nomi-

nations from the floor, the voting proceeded, after which ballots were collected and the tellers retired to count them.

The minutes of the previous meeting were read and approved.

The President announced that the Executive Committee had read all the annual reports of committees from which a number were selected to be read at this meeting.

Motion carried that the reports which were read, as well as those not read, be accepted and filed.

Dr. Alice Wakefield, Chairman, Special Committee on Physicians Exchange, requested an extension of time before a final report was made. Dr. Atherton asked the incoming president to appoint the same committee to continue their work.

Dr. Slucher, Chairman, Program Committee, stated the committee recommended the Society not to participate in the Telephone Seminar of postgraduate instruction and motion was carried to accept the committee's recommendation.

Dr. Joseph Bell, Chairman, Executive Committee, read letter from Dr. S. I. Kornhauser, Chairman, Library Committee of the U. of L., suggesting changes in the By-laws of the Society with reference to the Joint Library of the University and of the County Society. His proposal had been referred to the Executive Committee by the President for study and recommendations to be made at the annual meeting. The Executive Committee recommended that this matter be referred back to the Library Committee. Motion made by Dr. E. L. Heflin to refer this proposal back to the Library Committee for report to the Executive Committee, was seconded and carried.

Dr. Bell brought to the attention of the Society that facilities are available to the Society to meet in the new hall at Veterans Hospital if so desired.

The Executive Committee recommended that the traveling expenses of Dr. Thompson be paid, but that in the future such requests be voted upon by the Society before any commitment is made. Motion by Dr. David Cox that the Society sustain the Executive Committee in paying expenses of Dr. Thompson, was seconded and carried.

The Executive Committee considered requests from various doctors in Indiana to become members of the Jefferson County Medical Society in order to serve as staff members in hospitals in Louisville. Since this is contrary to the By-laws of the Society, their request was refused and Miss Walker was directed to so inform them.

The following new members were elected: Harry Flax, M. D., Active membership.

E. Alden Terry, M. D., Active membership.

A. Lemuel Rosenblatt, M. D., Associate membership.

The applications of Dr. George P. Beutel and Dr. George E. Vaughan for transfer to Emeritus list, were approved.

The resignation of Dr. Eleanor Townsend, because of change of residence, was accepted.

The Secretary read a communication from the Chairman of Public Health Committee endorsing the plans of the Louisville Nutrition Committee and the Louisville Heart Association. Motion that this report be accepted was seconded and carried.

Dr. Louis Foltz, Chairman, Public Relations Committee, reported on a meeting held to consider a bill now pending for treatment of alcoholics. The Committee recommended that a Resolution be sent to the Legislature, and a copy to the Committee on Legislation of the State Medical Association, giving the Society's opinion in the matter. Motion was made by Dr. Frank Powell that the Society go on record against the bill in its present form, was seconded and carried.

Dr. Clyde Foshee spoke briefly regarding the drive which will soon be made for funds to build a new building for the boys club of Portland Avenue.

The Secretary thanked the Secretary's Co-operative Committee for their work during the year.

The President made a closing address, ending with a motion that a special committee be appointed by the Society to contact the executive committees of each of the six general hospitals and arrange a round table discussion of the possibilities of establishing one general staff meeting a month in which representatives of all six hospitals would participate. If such a plan can be worked out, the Society could put the proposition before the American Medical Association and American College of Surgeons for their consideration. Motion was seconded. There was discussion by Drs. Charles Bryant, Joseph Bell, A. B. Loveman, Glenn Bryant, George Sehlinger, and motion carried.

The McDowell House Committee reported funds were exhausted and that \$500 would be needed to complete the furnishing of a room in the Society's name, and to repay a \$200 debt to the State McDowell House Committee. There was discussion and a motion by Dr. E. L. Heflin that the Society recommend to the Executive Committee that the Society provide funds necessary to finish the room. Dr. Bell stated the committee had already considered

it and felt the decision should be made by the Society as a whole. After discussion, it was decided that the \$500.00 should be taken from the general funds of the society.

The following officers were elected for 1952: President-elect, Arthur T. Hurst, M. D.; First Vice President, Thomas Van Zandt Guddex, M. D.; Second Vice President, Marvin A. Lucas, M. D.; Secretary, Robert C. Long, M. D.; Treasurer, Carlisle Morse, M. D.

The incoming president, Dr. Richard R. Slucher, was introduced by Dr. Atherton, who presented Dr. Slucher with a gavel as a personal gift.

Adjourned: 9:35 p. m.

Austin Bloch, M. D., Secretary

McCRACKEN

The January 23rd meeting was called to order at 6:30 P. M. with Dr. Blake presiding. There were 27 members present. After the dinner, the scientific program was given. Dr. R. G. Yancey, Madisonville, talked on the problems of tuberculosis in Western Kentucky and Dr. H. L. Gardner discussed problems associated with the operation of an A.E.C. plant.

Dr. R. W. Breytspraak was voted into the society by transfer from the consolidated Medical Assembly of West Tennessee under Section 2B of the by-laws stating that medical officers of "other governmental service while on duty in the State" may be received into membership without having a license in this State. The motion was made by Dr. Billington, seconded by Dr. Pace and passed.

The motion was made by Dr. Ward, seconded by Dr. Billington, and passed that Dr. Weaver be elected to act as medical director to meet with the Chamber of Commerce.

Dr. Billington moved that a representative from the Sun-Democrat be invited to attend the monthly meetings with dinners paid by the society, seconded by Dr. Blanton and passed.

Dr. Dunn moved, seconded by Dr. Ward and passed unanimously, that the legislative committee send a resolution by night letter to Representatives Morgan and Burnley and Senator Melton that the McCracken County Medical Society is in favor of passing the Hospital Licensure Act.

Much discussion was had concerning the problems and answers to the night call situation. Dr. Reeves made the motion, seconded by Dr. Ward and passed that the McCracken Medical Society authorize the establishment of a system of emergency medical call using the service of these physicians who wish to

volunteer for this duty and that they be authorized to use the services of 731 to facilitate the work of this group.

Adjourned at 9:30.

George H. Widener, Secretary

McCRACKEN

The regular monthly meeting of the McCracken County Medical Society was held February 27, 1952. The meeting was called to order at 6:30 P. M. with Dr. Blake presiding. There were 26 members present.

The scientific session consisted of a paper on "Antibiotic Therapy," presented by W. W. Taylor, M. D., Instructor of Medicine at the University of Tennessee.

Committee Reports:

Emergency Medical Service—Dr. Ward moved that programs for taking night calls should be dropped due to lack of men willing to cooperate and also tabling advertising. It was seconded by Dr. Keith and passed.

Legislative Committee—The committee reported that letters which were written to representatives and senators had been effective and that the Hospital Licensure Act passed.

The resolution of Dr. Shemwell was read by Dr. E. Pace. A copy was sent to the family, the state society, and a copy was kept for the minutes. The resolution was adopted.

Dr. Dunn reported that 16 members were at the telephone seminar and that it was very successful. Dr. Billington made a motion that a committee be appointed to report to Dr. Lich the favorable reaction to the seminar. Dr. Dunn was appointed.

Dr. Cunningham moved that Dr. Dobbs come before the society in April to talk on operation and organization of Baptist Hospital. It was seconded by Dr. V. Pace and passed.

Geo. H. Widener, M. D., Secretary

SCOTT

The Scott County Medical Society held its regular monthly meeting at the John Graves Ford Memorial Hospital on Thursday, March 6, 1952. The following members were in attendance:

Drs. D. E. Clark, Jr., F. W. Wilt, C. E. Barlow, W. S. Allphin, L. F. Heath, P. H. Crutchfield, H. V. Johnson and Dr. Rufus C. Alley, Lexington, Ky.

Guests present were: Mayor Joe E. Johnson, City Atty., Durward Weldon, Mr. Joe Kelly, Hospital Administrator.

Reading of the minutes was dispensed with.

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City Attorney, Durward Weldon made a report for the Red Cross and said they would like to bring a Blood-Mobile to Georgetown. After discussion it was moved we endorse the movement provided the blood is to be used by the Armed Forces or locally in case of disaster.

Mayor Johnson talked to the Society in regard to completing the City sewer system and also in regard to garbage disposal plans.

Dr. Alley was then introduced and he presented a most interesting paper on "Pain," stressing its significance and treatment.

There being no further business the meeting adjourned.

H. V. Johnson, M. D., Secretary

TRIGG-LYON-CALDWELL-CRITTENDEN

The Four County Medico-Dental Society held its regular quarterly meeting at the Princeton Hotel in Princeton, Kentucky, February 29, 1952.

Officers for the year, 1952, were elected as follows: Dr. G. E. Hatcher, Cerulean, President; Dr. Edward F. Dombrosky, Marion, Vice President; Dr. John Futrell, Cadiz, Secretary-Treasurer. Dr. John Cothoff, Princeton, was elected to membership.

Elias N. Futrell, M. D., Secretary

UNION

The regular meeting of the Union County Medico-Dental Society was held February 26, 1952, at 7 P. M. at Our Lady of Mercy Hospital.

The meeting was called to order by the President, Dr. William Humphrey. The minutes of the last meeting were read and approved.

A communication from the American Can-

cer Society was read regarding the possibility of having the Cancer Mobile Diagnostic Clinic come to this county. It was decided that John B. Floyd, Jr., M. D., director for the cancer clinic, be notified that the society is desirous of their services; a date for this clinic will be arranged.

A communication from Walter L. O'Nan, M. D., the councilor for this district, was read on the subject of "Constitutions and By-laws for the Society and the Adoption of the Same." As we do not have a record of the above it was decided we adopt the model as used by Paducah. The motion was made by Dr. Carr and seconded by Dr. Cottingham.

At 7:30 the Telephone Seminar came on. This program was enjoyed by all. The subject was interesting, instructive and well presented, and we feel it was well worth while. We will be looking forward to March 18th for the next seminar.

Members present were: Drs. H. B. Allen, G. B. Carr, C. P. Cottingham, H. B. Stewart, C. B. Graves, William Humphrey and George Higginson.

A. W. Andreasen, M. D., Secretary

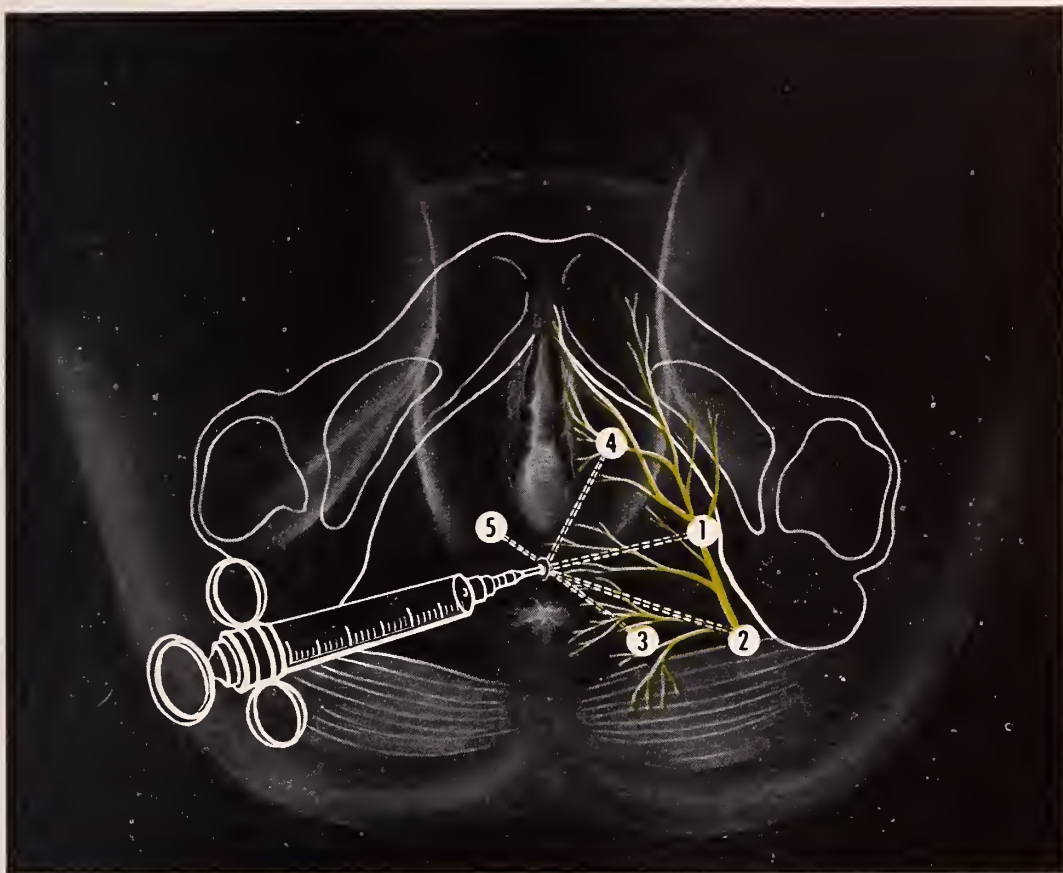
WARREN-EDMONSON-BUTLER

The February meeting of the Warren-Edmonson-Butler County Medical Society was held in Bowling Green at the Helm Hotel.

Dr. W. C. McCormack was elected delegate to the State Convention and Dr. Richard Grise was elected as alternate.

The scientific program was presented by the University of Louisville School of Medicine through the Telephone Seminar, as worked out by the Kentucky State Medical Association. The subject was "Jaundice" and was extremely interesting.

Frank H. Moore, M. D., Secretary



Sites for injection of local anesthesia in obstetrics. Sites 1 to 4 should be similarly injected on the contralateral side. Site 5 is for episiotomy. Adapted from Johnson, O. J.: Nerve Block in Painless Childbirth, *J.A.M.A.* 145:401 (Feb. 10) 1951.

Pudendal Block in Obstetrics Simplified with **ALIDASE**

Using a local anesthetic with hyaluronidase, Heins¹ reports: "Complete perineal anesthesia is practically instantaneous. . . . The technique of pudendal block is greatly simplified. The operator does not have to inject the nerve per se, but infiltration in the vicinity of the nerve will accomplish an effective block."

Baum² states: "The use of hyaluronidase is found to be a safe and simple method for increasing the efficiency of pudendal block in obstetrics and for overcoming many of the objections to this type of obstetrical anesthetic."

ALIDASE[®]—highly purified, well tolerated brand of hyaluronidase—definitely shortens the period between completion of the block and establishment of operating analgesia. Swelling, induration and discomfort are almost negligible with Alidase.

¹Heins, H. C.: Pudendal Block with Hyaluronidase, *J. South Carolina M. A.* 46:309 (Oct.) 1950.

²Baum, F. E.: The Use of Hyaluronidase in Pudendal Block, *Am. J. Obst. & Gynec.* 60:1356 (Dec.) 1950.



News Items

Bessie Lee Allnutt, M. D., a 1949 graduate of the University of Cincinnati College of Medicine, has located at 302 Earl Avenue, Covington, for the practice of psychiatry. Dr. Allnutt interned and took her residency at the University of Virginia hospital.

Benjamin A. Cockrell, M. D., a graduate of the University of Louisville Medical School in 1910 and formerly of Chicago has been made manager of the 300-bed Tuberculosis Hospital the Veterans Administration operates at Memphis. Dr. Cockrell, a veteran of World Wars I and II, was born at Wades Mill, Kentucky.

John G. Coleman, M. D., who has just completed a tour of duty in the Armed Service, has located at 115 East Maxwell, Lexington, and will limit his practice to surgery. Dr. Coleman graduated from the University of Virginia Department of Medicine in 1941.

Walter B. Grenell, M. D., has taken over the Haws Memorial Hospital, Fulton. Dr. Grenell comes to Fulton from Union City, Tennessee, where he has been practicing for the past 16 months. He is a graduate of Northwestern University School of Medicine, class of 1947.

In Memoriam

IN MEMORIAM

A. J. HILLMAN, M. D.

Ashland

1870 - 1952

Dr. Andrew Jackson Hillman, who had practiced medicine in several Eastern Kentucky counties, died December 4 at his home in Ashland.

Dr. Hillman retired from active practice 20 years ago.

He was born in Elliott County, on July 7, 1870. In 1897 he graduated from the Hospital College of Medicine, Louisville, and immediately began his medical practice.

He was a past president of the Boyd County Medical Society and was a former member of the Ashland Board of Education.

W. L. MOORE, M. D.

Madisonville

1866 - 1952

Dr. William Lee Moore, a physician since 1896 who practiced at Morton Gap and Nortonville before he came to Madisonville in 1930, died at his home February 9th after several months of illness.

Two months ago, he retired as councilman from the Third Ward of Madisonville after serving for two years. He declined to be a candidate for re-election. Dr. Moore was a member of the Madisonville First Baptist

Church, the Madisonville Woodmen of The World, and had been a member of the Masonic Lodge for 52 years. He graduated from the Barnes Medical College in 1896.

CHARLES E. SMOOT, M. D.

Richmond

1875 - 1951

Dr. Charles E. Smoot, Richmond, died October 23, 1951 following a heart attack. He was born in Mason County, Kentucky, June 21, 1875. He attended Central University formerly located in Richmond, and was graduated from the Homeopathic Medical College, Chicago in 1899. He practiced medicine for over fifty years. Dr. Smoot was prominent in civil and medical circles in Central Kentucky. He was a member of Sigma Alpha Epsilon fraternity. He was a member of the Exchange Club, Madison County Medical Society, and the First Christian Church.

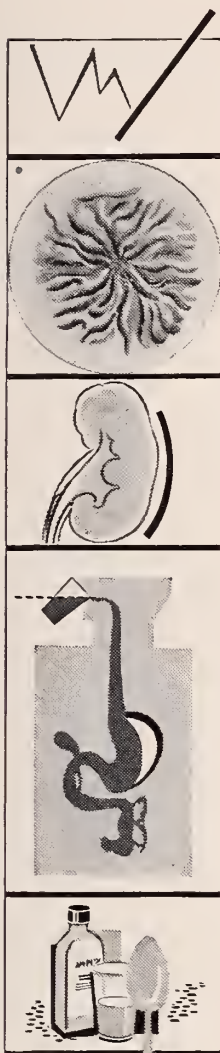
C. F. BURKHARDT, M. D.

Biloxi

1868 - 1951

Dr. C. F. Burkhardt, native of Grant County, Kentucky, died November 6, 1951, in Biloxi, Mississippi where he has been a resident for the past seventeen years. Dr. Burkhardt was a retired physician and surgeon, and was graduated from the Kentucky School of Medicine, Louisville, in 1893. He later served as superintendent of schools at Gallatin, Kentucky, and moved from there to Effingham, Illinois where he practiced medicine, and later retired to Biloxi.

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BOOK REVIEWS

DYNAMIC PSYCHIATRY, Basic Principles, Volume One by Louis S. London, M. D., Washington, D. C. Corinthian Publications Inc., New York 16, N. Y., Publishers. Price \$2.50.

Dynamic Psychiatry may be defined as a struggle between the instinctive desires or ID, and the opposing forces of the superego and morals. In this volume, are discussions of the evolution of Psycho-Therapy from Freud whose sexual discoveries startle the world to the present time.

Most of the chapters are devoted to Libido in all its phases and development. This volume gives the general practitioner some idea of the complexity of the various forms of psychological conditions of the mind arising from the sex impulses, and also serves as a guide in handling these baffling cases, or at least makes the physician conscious that such conditions exist.

DOCTORS IN BLUE. The Medical History of The Union Army in The Civil War, by George Worthington Adams, Dean and Professor of Histories, Colorado College, Henry Schuman, Incorporated, 20 E. 70th Street, New York 21, N. Y. Publishers. Price \$4.00.

Based on extensive study of surgeon's reports, inspectors observations, soldier narratives and other first-hand materials, this book fills a long glaring gap in the story of American medicine and the history of the American Civil War.

Dr. Adams, already distinguished for research in Confederate experience, develops the subject of health and medical practice on the Union side with remarkable skill and balance.

Disease, on the Northern side as on the Southern, was far more deadly to the fighting men than were the bullets of their opponents. Behind the sickness and mortality statistics of the Civil War lay ignorance, stupidity, inefficiency, and jealousy. But behind them also, are to be seen earnestness, cooperative spirit, and great strides of scientific knowledge.

Many aspects of the Civil War have been written about profusely but the important theme of medicine has never before had its general historian.

In this book the reader will find a warm and human story of the contributions made by the great military medical men of the period and a compelling picture of the roles played by the hospital attendants, ambulance men and the army's first women nurses. Dr. Adams has given us a superb survey of the medical history of the Union Army in the Civil War.

PENICILLIN DECADE 1941-1951: Sensitization and Toxicities by Lawrence Weld Smith, M. D., Medical Director, Commercial Solvents Corporation. Ann Dolan Walker, R. N., Former editor "Trained Nurse and Hospital Review." Publishers: Abundel Press, Inc., P. O. Box 2606, Washington 13, D. C. Price \$2.50.

This volume comprising 122 pages gives a detailed description of a decade in the use of penicillin. A story of its discovery is briefly told and the context includes an account of the use of the wonder drug in the various diseases for which it is considered a specific. Its allergic properties are discussed and the treatment of the various reactions. It also issues a word of warning against regarding its indiscriminate use or any other biotics for that matter. After reading the book the physician should realize the great responsibility for the wise application of penicillin in clinical practice.

ANNUAL REPORT ON STRESS by Hans Selye, M. D., Ph.D. (Prague), D. Sc. (McGill), F. R. S. (Canada) Professor and Director of the Institute de Medicine et de Chirurgie experimentales Universite de Montreal. ACTA, INC. Medical Publishers, 5465 Decurie Boulevard, Montreal Canada. Price \$10.00 plus 34c mailing charges.

This volume represents the first of a series of annual supplements to the book "Stress," the physiology and pathology of exposure to Stress.

Every effort has been made by the author to expedite the task of finding specific information concerning any one problem that causes stress in human affairs including disease. To administer a drug without knowing why and how its acts is not scientific. Why does malaria respond to quinine or various vaccinations prevent their appropriate diseases? The author of the book has evolved a theory that seems acceptable so far as an answer to these problems, as some common medical X must be at work, which the author calls "Stress."

The book is not meant to be read from cover to cover, as it is more of a reference volume, highly technical but contains valuable information regarding the mechanism of "Stress," the General Adaptation Syndrome G-A-S.

If Dr. Selye's theories are further borne out by more experimentations with animals, we are in the midst of a medical revolution.

The New York Times Magazine, December 16th, contains an article on Cortisone and Acth, an essay that discusses from a layman's point of view these wonder drugs and Dr. Selye's contribution to some of their mystery reactions. It is well worth reading.

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NO. 5

The Medical Management of Anuria and Oliguria

CARL H. FORTUNE, M. D.

Lexington

I appreciate deeply the honor of delivering the Oration in Medicine at the Centennial Meeting of the Kentucky State Medical Association. I have chosen to discuss the clinical handling of oliguria, that is, inadequate urine formation, and anuria, or cessation of urine secretion, both of which represent varying degrees of the same pathological process. These conditions present a medical emergency, which if unrelieved leads to death, and which in certain cases will respond to proper treatment in a most gratifying manner. Much has been learned of renal anatomy, physiology and pathology since Bowman in 1842 demonstrated, by the injection of red lead, that the striae of the kidney are in reality tubular structures connecting with the glomeruli,—a conclusion postulated by Malpighi in 1666 almost 200 years earlier. With increased knowledge has come proportionate improvement in the possibilities for clinical evaluation and treatment. Lest we relax in the false security of simplified regimes and laboratory aids to diagnosis, it is perhaps worth while to consider briefly how the clinician of 100 years ago studied his patient and applied such knowledge as was available to him in meeting the problem of anuria.

On Tuesday, September 9, 1851, Dr. James McGrath was called to see a woman of 23, in her eighth month of pregnancy, whose illness and subsequent recovery he reported in the *American Journal of Medical Sciences* of the following year¹.

He says: "I found her sitting up in bed, her head supported by a female friend, her face was of a pale livid or sallow colour and seemed oedematous, her eyes were suffused, her whole countenance was expressive of severe suffering and great anxiety, her pulse so feeble as to be barely perceptible. I was told she had fainted several times and had something like convulsions; that she was unable to lie down from the feeling of weight about her heart, which seemed to suffocate her. On examining the chest, loud mucous rales were audible. The heart's action was rapid, with feeble impulse; the sensibility of the skin was so morbidly increased as to render an examination almost impossible, the slightest touch causing severe pain. I was informed that she had several loose discharges from the bowels during the day, but had passed no water from the previous Sunday (2 days). I now introduced a catheter to relieve the bladder, but, to my surprise, it contained not a drop of urine." A discussion of the treatment administered would be of only historical interest. In each instance the therapeutic measure was instituted because in the light of the knowledge available it seemed directed against an observed clinical condition. The cupping, bleeding, hot fomentations and drugs seem illogical and even detrimental in the light of present day thinking, but in the thinking of 100 years ago, each was directed against some phase of the pathology as visualized from observation of the patient. Significantly, in his oedematous patient with pulmonary oedema he gave his medicines

¹Uration in Medicine before the Ephraim McDowell Memorial Meeting, the Centennial of the Kentucky State Medical Association, Louisville, October 2-5, 1951.

with "tea or barley water for drink, sparingly."

The anuria continued 36 hours longer and then quoting: "After a night of great and increasing restlessness with delirium lapsing into stupor, I had the satisfaction to find . . . that about an ounce of high-coloured urine had been voided with considerable pain. In the course of the day the secretion became re-established, and as the urine became abundant all the more urgent symptoms began to disappear, leaving my patient in a state of extreme debility, from which she slowly rallied." The report goes on to state that 2 weeks later she was delivered of a premature living infant and that mother and child did well.

I have quoted extensively from this report, not because it adds anything to our knowledge of treating anuria and not with the intent of speculating on the pathology present, but rather because of the method in which the problem was approached. The patient was first studied and the description given indicates careful observation. Conclusions were drawn and treatment planned on the basis of the pathology conceived to be present. Since complete anuria or scanty urine is always such a serious problem with a fatal outcome if it continues long enough, the natural desire of the physician is to do something promptly. It is well to remember Dr. McGrath's reflection in 1851 when his patient urged him to bleed her at once when he first saw her:—"This, however, I was unwilling to do until I had fully satisfied myself of the nature of her illness, and of its propriety." Time prohibits a more detailed report of this case of 100 years ago. It is my purpose to emphasize in the remainder of this presentation the careful clinical evaluation of the patient with oliguria or anuria and the planning of treatment in the light of what we now know of renal physiology and pathology.

Any detailed discussion of the causes of oliguria and anuria would be lengthy and involved. It is convenient, however, to think of a group in which the pathology is not primarily in the kidney, a group in which anuria is primarily of renal origin, and a third group in which the primary pathology is extra-renal, but in which the persistence of anuria or oliguria is due to secondary changes within the kidney. In certain cases, the extra-renal cause can be eliminated or the renal pathology is reversible and, with proper handling,

complete recovery may be possible. The corollary also follows that incorrect handling may cause unnecessary deaths.

This paper is concerned with the medical treatment of oliguria and anuria, in which our present knowledge gives reasonable hope of relief with proper handling. It is obviously impossible to discuss in detail the complicated physiology and pathology involved and no attempt will be made to present an exhaustive study. I shall not attempt to discuss the oliguria due to congestive heart failure,—if the heart failure is successfully handled the oliguria is relieved. The relief of mechanical blockage to the outflow of urine is essentially a surgical problem. Oliguria or anuria when found in chronic kidney disease usually is a sign of impending death. Extensive destruction of functioning kidney tissue is present and we have no treatment which offers more than temporary benefit. I shall limit my discussion to the following causes of anuria: dehydration, acute nephritis, eclampsia, and that ill defined group variously designated as lower nephron nephrosis, hemoglobinuric nephrosis, shock kidney and anoxic kidney.

Dehydration is a common cause of scanty urine. The importance of adequate fluid to normal renal function is not a new idea. However, it was the work of Newburgh and Lashmet² and of Collier and Maddock^{3,4} in 1933 which called attention to the fact that in certain conditions causing dehydration the amount of fluid customarily given was often inadequate. The amount of urine secretion necessary for adequate kidney function obviously varies with the health and efficiency of the kidney. In kidneys capable of secreting a highly concentrated urine 5-6 hundred c.c. of urine a day is adequate output. In kidneys damaged so that only a dilute urine can be excreted 1000 to 1600 c.c. of urine may be necessary to prevent azotemia. Adequate fluid must be administered by mouth or parenterally to provide this. The extreme fluid loss which may occur in certain medical and surgical conditions may cause serious oliguria or even anuria unless careful attention is given to fluid intake. Among these may be mentioned persistent vomiting, intragastric suction drainage, external biliary drainage, excessive sputum, diarrhea, heat stroke, uncontrolled diabetes, and sepsis. Almost all postoperative patients are subject to some fluid deficiency from

temporary lack of fluid intake and this may be aggravated by blood loss, draining sinus, enterostomy or colostomy and pleural or peritoneal fistula. The authors quoted above emphasized also the so-called insensible loss of fluid; that is, loss by evaporation from the skin and in the moisture of the breath. In the normal individual in temperate weather this approximates a litre a day and with fever, hyperthyroidism, or excessive sweating the amount may be double or even more. In cases where dehydration is present due allowance must be made for replacement of lost tissue fluid. By noting these factors involved one can estimate the fluid requirements and by noting the urinary output and its specific gravity he can maintain a fair check on the adequacy of his estimate.

The choice of fluids to be used when it is necessary to resort to parenteral fluids introduces the difficult problem of electrolyte balance. In many cases where dehydration is present there has been sodium loss so that sodium chloride is indicated, but if too much is given, sodium may accumulate in the tissues creating the paradox of an oedematous patient who has oliguria because there is not sufficient fluid in the circulating blood. Potassium deficiency or excess and chloride deficiency are also factors of importance. Adequate controls on electrolyte levels add greatly to the facility of maintaining proper balance, but unfortunately rapid and accurate sodium and potassium determinations are not always available. Furthermore, because potassium is so largely concentrated within the body cells, serum levels of potassium may even be misleading. The characteristic changes in the electrocardiogram occurring in potassium deficiency or excess are often very helpful. Much can be inferred from blood chloride and carbon dioxide combining power. When none of these adjuncts are at hand, the careful observer can tell a great deal by watching the patient. Beginning oedema will often be a clue to excess sodium intake. Dryness of the skin and mucous membrane with adequate urinary output may suggest sodium deficiency. Judicious ordering of infusions in saline or Ringer's solution and infusions in distilled water can usually carry the patient through until such time as feedings by mouth are possible. Potassium deficiency can be safely treated with potassium chloride by mouth if the pa-

tient can take it, and if urine secretion has been restored, but intravenous use of potassium should be approached with great caution because the margin of safety is narrow. Ringer's solution is usually safe, however, and may help. Careful day to day observation rather than a standing order for fluids, will avoid many of the pitfalls of inadequate fluid intake, as well as disturbed electrolyte balance. The improved handling of fluids in the postoperative patient during the past 20 years indicates that simple recognition of the importance of this phase of treatment is a long step toward satisfactory solution of the problem.

An entirely different approach to the treatment of oliguria and anuria is indicated where important disease of the kidney exists. Acute glomerular nephritis, or, if you wish, the acute phase of glomerular nephritis, is a well recognized clinical entity with many variations in pathology. The damage is primarily in the glomerulus and oliguria is the rule, occasionally anuria. This is due to inability of the damaged glomerulus to produce a glomerular filtrate, or at least an adequate amount of filtrate. There is no dehydration, in fact, there is apt to be oedema and excess fluid in the blood. No specific therapy is at present available for the nephritis and dependence is placed on the recuperative power of the kidney. This is so great that death seldom occurs in this phase of the disease if the patient is well handled.

In the treatment of the anuria of acute nephritis, as pointed out by Addis⁵, methods taught range all the way from no fluid to forcing fluid. Addis states that he knows of no evidence that forcing fluids has appreciably increased the flow of urine in acute nephritis, and on the other hand there is definite danger of inducing or augmenting pulmonary oedema and causing dilatation of the heart. If the patient is able to take fluids by mouth he recommends giving only what thirst dictates. Where there is vomiting parenteral fluids are indicated, but only to replace the fluid loss. It should be remembered that there is sodium retention in acute nephritis so that parenteral fluids should be given in distilled water. It may be asked why any fluid is necessary in the presence of oedema, but as pointed out by Corcoran and Page⁶, the oedema of acute nephritis is in part due to sodium retention and in part exudative, and only

in part due to inability of the glomerulus to filter urine. Accordingly most of the tissue fluid is not available to form urine at this stage. There is no evidence that hypertonic glucose or any of the diuretic drugs have a beneficial effect. There is at least the possibility that drugs may increase the kidney damage. Infection greatly increases protein breakdown and consequently azotemia. Bull and his associates⁷ routinely give penicillin in the presence of pulmonary oedema in an effort to prevent pneumonia. The uremic patient is much more susceptible to infection and the physician should be alerted to watch for the first signs of such a complication. Prompt antibiotic treatment is indicated, but any agent which may increase renal damage, such as a sulfonamide, should be avoided. Because of poor excretion penicillin and other antibiotics may be effective in smaller doses. If the patient can eat, most writers now advocate a diet low in protein and relatively high in calories. Masson, Corcoran and Page⁸ have shown in experimental animals, that if energy requirements are supplied almost entirely by carbohydrate and fat, protein katabolism is depressed. Borst⁹ has devised a "butter soup," which is an emulsion of salt-free butter and sugar, flavored with coffee. By urging to take this mixture he is usually able to get a daily caloric intake of about 1775 calories. He states that by this diet and prevention of infections dangerous azotemia may be postponed for 3 weeks, even though the patient is anuric. This period is enough to allow spontaneous recovery in many cases of acute nephritis. Bull⁷ finds that many patients cannot take the "butter soup" because of nausea and vomiting. He has substituted an emulsion of peanut oil and glucose which he gives through a nasal tube into the duodenum. If skillful handling carries the patient through this acute anuric phase, spontaneous diuresis generally occurs. At this stage the diet may be liberalized and made more palatable, and urinary loss of water and electrolytes should be replaced.

As pointed out by Scadron and Roth¹⁰ the cause of eclampsia is not known and much of the physiology and pathology is poorly understood. Allen¹¹ has described a variety of acute membranous glomerular nephritis which he considers to be peculiarly associated with eclampsia. Maigrath and his associates¹² and Odel¹³ consider eclampsia as one of the causative

agents of the lower nephron syndrome which will be discussed later. Willson¹⁴ takes the position that anuria is generally due to hemoconcentration and that in most instances the kidneys will secrete if fluid is supplied. In spite of these wide differences in opinion concerning the pathology back of eclampsia, the general opinion seems to be that treatment of the anuria should be along the same lines as treatment of the anuria of acute glomerular nephritis.

A vast literature has accumulated in the last few years concerning the last group of acute renal disturbances which is to be discussed. So great is the divergence of opinion among various investigators and clinicians that no descriptive name has emerged which is satisfactory to all. Lower nephron nephrosis is perhaps the most popular term, but many writers insist that it is not primarily a disease of the lower nephron. Hemoglobinuric nephrosis is an earlier description still advocated by some, but the clinical picture can occur without either hemoglobin or myoglobin being deposited in the kidney tubules. Crush syndrome describes certain cases. Maigrath, Havard and Parsons¹² suggested the term renal anoxia syndrome, a name which emphasizes a feature considered by many of utmost importance. The clinical syndrome which most writers have in mind is initiated by a wide variety of seemingly unrelated insults to the body. In its initial phase there is usually the pattern of shock with anuria or scanty urine of normal specific gravity. In the full-blown picture this oliguria does not respond to the usual treatment for shock, although the patient's general condition is improved. The character of the urine, if any is passed, changes and the specific gravity becomes fixed in the neighborhood of 1010. Nitrogen retention develops as the anuria or oliguria persists, and at the end of about 7 to 10 days death occurs from renal failure or else spontaneous diuresis ensues, followed by slow and usually complete recovery. Certain writers, such as Gaberman¹⁵ and his associates have included cases of marked nitrogen retention with ample urinary output, often with a slow and insidious onset. This discussion, however, is concerned only with the clinical picture just outlined in which oliguria or anuria is a prominent feature.

The conditions which have been described as initiating the picture are many

and diverse and any orderly classification is difficult. Prolonged shock is one of the most common, and may be post-operative, traumatic, secondary to severe hemorrhage or from a catastrophe such as acute coronary occlusion, or perforation of a viscus. Any condition causing intravascular hemolysis of blood may be causative, such as transfusion with incompatible blood, black-water fever, and occasionally introduction of hypotonic fluid into the blood stream, as in the irrigation of the bladder with water solutions during transurethral prostatectomy. A related condition is the crush syndrome in which myoglobin is released into the blood. Hemoconcentration, as in heat stroke, and extensive cutaneous burns may set off the process. The so-called hepatorenal syndrome is classified in this group, as is also eclampsia by many. Certain sulfonamide reactions and poisonings by various chemicals, radiation sickness and a diverse list of acute infections have been implicated.^{10, 12, 13, 16, 17}

Considering this heterogeneous group of causative factors, it is understandable that there is considerable disagreement among competent observers concerning the pathology and altered physiology involved. It seems reasonable that the one common denominator is a similar clinical course. The discussion of Van Slyke¹⁸ is a lucid and logical treatment of this problem. He considers the first or "shock phase" to be due to renal ischemia. He points out that 40 to 60 mm of mercury blood pressure is essential for the filtration of urine. An ineffective filtration level is reached in the renal glomerulus before the peripheral blood pressure has reached this level, because of reflex vasoconstriction of the renal arterial system. This is part of the body's protective attempt to maintain a higher pressure in areas more sensitive to anoxia, such as the brain. Trueta's postulation of an arterio-venous shunt in the juxta-medullary region, made as the result of experimental work in the rabbit, is interesting but has not yet been demonstrated in the human. Anuria or oliguria in this early stage may be assumed to be due to ineffective filtration pressure in the glomerulus.

The second stage is a stage of renal damage, which is largely confined to the tubules in the lower part of the nephron. Within 24 hours there is lipid degeneration of the ascending loop of Henle. In 24 to 72 hours there are deposits of hemo-

globin or myoglobin in the tubules, forming pigment casts. Corcoran and Page¹⁹ and Mallory²⁰ consider these casts to be important factors in the ensuing renal damage. By the third to fifth day necrosis of cells has occurred and at the same time beginning regeneration of tubular epithelium is occurring.

There is disagreement as to why oliguria and anuria persist in the second stage. There is a theory that blockage of renal tubules by pigment casts is the main factor. In kidneys examined the number of blocked tubules does not seem adequate for this and dilatation of the upper nephron and Bowman's space is not always present. The most generally accepted theory, although by no means universally accredited, is that the damaged tubular epithelium acts as a dialyzing membrane and that the urine is reabsorbed along with its excretory substances by process of osmosis. Allen¹¹ discards this mechanism as inadequate and believes there is failure of glomerular filtration due to prolonged vaso-constriction of the glomerulus, augmented by interstitial oedema and the factors mentioned above.

The third stage, or stage of diuresis, is due to partial recovery of the kidney from damage mentioned. Complete recovery may require a long time but sufficient return to normal physiology has occurred to allow adequate urine formation.

These theoretical considerations have been discussed in some detail as a basis for a regimen of treatment which has strikingly reduced mortality in this condition. In the first or shock phase, the usual measures for relief of shock are indicated. The blood volume should be restored, using blood, plasma, intravenous glucose, or combinations of these as indicated. Alkali has been recommended in case intravenous hemolysis has occurred, but its value has been questioned and there is the hazard of upsetting the electrolyte balance, since the patient is not excreting sodium in the urine. If prompt measures are employed, urinary filtration may be resumed and the full-blown picture may be averted.

In many cases, however, anuria or oliguria persists after the clinical picture of shock is relieved. It is at this point that skillful handling is most important, and that over-enthusiasm may result disastrously. It is sometimes extremely difficult to be conservative in the face of anuria or oliguria with an ever-increasing

nitrogen retention. However, forcing fluids in an already hydrated patient, who cannot secrete urine, is likely to cause fatal cardiac or pulmonary embarrassment. The best results are obtained by remembering that the kidney tubules have great power of regeneration, and that if the patient can be kept alive for a week to ten days, the chances of recovery are good. At present we have no drugs which favorably influence the course of the disease. A few cases of improvement following splanchnic block have been reported. It is generally agreed that diuretics are of no benefit and that possibly they may be harmful.

Maitland^{21,22} in 1941 advocated the use of isotonic sodium sulfate solution in the crush syndrome and felt that diuresis occurred as a result. Olson and Necheles²³ produced anuria in dogs by cutaneous burns. They reported that sodium sulfate consistently relieved the anuria whereas other agents were relatively ineffective. They were able to demonstrate no toxic effects. There has been considerable discussion of this agent, but the majority now consider that it is of little value and that when diuresis occurs it is simply fortuitous. There seems to be some danger in the introduction of sodium and sulfate ions into the blood stream when the kidney is incapable of normal secretion. The use of isotonic sodium sulfate is therefore not recommended.

Such agents as peritoneal lavage and the artificial kidney may, no doubt, be life saving in certain cases. They have their own hazards, however, and are not available to most physicians. Muirhead²⁴ and his associates still feel that in most cases such measures do not appreciably increase the rate of recovery, and that at the present time, the risk of procedure outweighs its value.

Replacement transfusion has been used when extreme uremia portends a fatal outcome. This consists of simultaneously bleeding the patient from one arm and introducing blood into the other arm. Bessis²⁵ states that 15 litres of blood is necessary to get 95% replacement of the patient's blood by this method. In anuric uremia, however, he recommends 5 litres every second or third day. He states that the blood urea nitrogen rarely shows much improvement following the first replacement transfusion, but that significant improvement follows subsequent

transfusions. There are obvious practical difficulties in this form of treatment and it probably can be rarely used. Experimental use of intestinal dialysis indicates that it may be of value in removing nitrogenous waste and also helping in restoration of electrolyte balance. As reported by Kolff²⁶ the method consists of passing a hypertonic solution through a duodenal tube depending on peristalsis to move the fluid through the bowel so that it can be recovered from a tube in the rectum. Practical difficulties now make its general use unwise, but it may later develop into a valuable method of combatting uremia in the anuric patient.

At present treatment should aim at keeping the anuric or oliguric patient in as good general condition as possible. Feeding by mouth is often difficult because of anorexia and vomiting. As in acute nephritis, such diet as can be given should be high caloric and largely carbohydrate and fat. When the patient cannot be fed by mouth,—as is often the case, the handling of fluids is most important. A good rule is to replace the fluid lost by vomiting, by insensible loss, by bleeding or draining sinus and such urine as is passed. Some chloride and sodium may be lost and electrolyte balance must be remembered, but in general there is sodium and potassium retention. An interesting idea proposed by Hoffman and Marshall²⁷ is the deliberate production of oedema by giving sodium chloride infusions and 6 molar sodium lactate. In this manner they seek to reduce the nitrogenous products in the blood by retaining a portion in tissue oedema fluid. This requires most skillful observation to avoid pushing the process far enough to give a disastrous pulmonary oedema.

If the clinician has skillfully handled the patient during a week or more of anuria he may be rewarded as was Dr. McGrath 100 years ago by a marked diuresis. The worst of the ordeal is over, but it must be remembered that the diuresis is attended by sodium loss. Some patients have collapsed at this stage from loss of electrolytes, and sodium chloride should be provided. Potassium chloride by mouth may also be indicated. The successful handling of such a patient calls for much skill, patience, restraint and thought. The reward of watching the satisfactory recovery of an individual who has passed through such a crisis justifies all the effort expended.

In summary, it is well to remember that 100 years ago patients sometimes recovered from prolonged anuria and oliguria. The years of research and clinical observation since then have not given us a perfect answer to the problem but have given us a knowledge of physiology and anatomy on which to base a rational program of treatment. Anuria may be due to conditions outside the kidney, may be primarily due to kidney disease, or may be due to an outside factor with the kidneys secondarily involved.

Proper handling of anuria and oliguria is dependent on careful consideration of the patient, determining as far as possible the etiology of his difficulty. Intelligent control of fluid intake is probably the most important factor in the treatment. Where there is dehydration, adequate fluid must be supplied. Where anuria is due to inability of the kidney to secrete urine, forcing of fluids may result disastrously. Electrolyte balance is important in choosing the type of fluid, the fluid requirement of the body is important in determining the amount to be given. Laboratory aids are extremely valuable, but now, even as it was 100 years ago, there is no substitute for careful study of the clinical picture presented, careful thought about what has happened to the patient's physiology, and careful day to day observation of the progress of the illness.

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Pediatric Surgery Comes of Age

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One hundred years ago, this State Association was conceived and born. At that time, a century ago, pediatric surgery as such wasn't even a gleam in its father's eyes. At the turn of the century, when this State Association was a well developed and functioning unit of fifty years of age, pediatric surgery was still in a nebulous state; however, this stepchild of surgery has gone through most of its "growing pains" during the past twenty-five years and has now evolved into an entity that demands the respect and consideration that is due its maturity and importance. So, pediatric surgery has come of age!

To say that pediatric surgery has come into its own within the past twenty-five years may seem to be an extravagant statement; nevertheless, one has only to pick up a "standard textbook" of twenty-five years ago and read some of the declarations that were made and accepted at that time in regard to pediatric conditions and problems. In these texts, many conditions were described and then dismissed as being uniformly fatal and not amenable to any type of surgical intervention. Today, these same conditions are seen, diagnosed and surgically corrected with almost monotonous frequency. It is a revelation to look through a text printed fifty years ago and realize that many of the conditions that are corrected by surgery today are not even mentioned in it. One such text, *Diseases of Infancy and Childhood* by L. Emmett Holt, M. D.,¹ was printed by D. Appleton and Company in 1901. From time to time, in this paper, sentences will be taken from this text to stress a point.

At this time, it might be well to more or less define pediatric surgery as well as a pediatric surgeon. Simply because the patient on the table in the operating room is less than thirty inches in length and the surgeon and nurses have included some mosquito forceps in the "set-up,"—plus the fact that the surgeon is going to close the peritoneal cavity with fine catgut

suture material and the fascial layers with fine silk rather than "number two chromic catgut, doubled with a knot in the end" does not mean that the surgery about to be done will be "pediatric surgery." Any one who does pediatric surgery must first understand and acknowledge that there is a difference in the physiology of the newborn, or an infant of several weeks or months of age, as compared with that of an average adult. Holt and McIntosh in their tenth edition of *Diseases of Infancy and Childhood*² make the statement that "What is really peculiar to children belongs especially to the first three years of life, before speech has developed. During this period the chief and almost sole reliance of the physician must be upon the objective signs of the disease. It is not so much that diseases in early life are peculiar, as that the patients themselves are peculiar."

The surgeon must recognize the startling rapidity with which a tiny infant can change his entire appearance, his state of health and/or degree of seriousness. He must go into such surgery with the capability of following ALL of the major principles of surgery which include, among other things: gentleness in handling of tissues; careful hemostasis and meticulous re-approximation of similar tissues. He must realize the post-operative infant is an entirely different patient than the average adult in the post-operative period and that he requires more careful and watchful treatment. These are just a few of the major considerations that differentiate pediatric surgery from general surgery.

The following is a "break-down" of the death rate in the City of New York from 1890 to 1892, inclusive:

Under one year.....	32,916—26%
1 to 2 years.....	10,547— 8%
2 to 5 years.....	9,794— 7%
5 to 15 years.....	5,470— 5%
Over 15 years.....	69,409—54%

128,136

In 1900, the population of New York City was 1,850,093. The death rate, as shown in the above table, is staggering.

¹Oration in Surgery delivered before the Ephraim McDowell Memorial Meeting, the Centennial of the Kentucky State Medical Association, Louisville, October 2-5, 1951.

In this table we are interested primarily in the first two groups; namely, those up to five years of age. One wonders how many of the children under the age of five had remediable surgical conditions that were not recognized, and how many cases of congenital hypertrophic pyloric stenosis, or atresia of the duodenum or jejunum, or incomplete rotation of the cecum with complete obstruction of the duodenum were "signed out" as "cyclic vomiting" or "feeding problems." One could go on through the entire list of anomalies of the intestinal tract, for example, that are amenable to surgery and conjecture how many of these children were listed in the "obit" column as marasmus, chronic diarrhea, intestinal hemorrhage and the like.

Congenital Hypertrophic Pyloric Stenosis:

The following are a few excerpts taken from texts^{1&3} printed in 1901 and 1919:—

"In very rare instances dilatation (of the stomach) may result from congenital stenosis of the pylorus. The most important predisposing cause, however, is the muscular atony which accompanies rickets."

"Stenosis may occur as a congenital malformation. Hyperacidity is believed to be responsible for some cases of spasm of the pylorus resulting in hypertrophy. Thomson believes that by the ingestion of liquor amnii in intra-uterine life both the stomach and the pylorus are excited to over-action, due to the presence of this irritant fluid."

"The prognosis in dilatation of the stomach is good except when it is due to pyloric stenosis."

Pyloric stenosis had been recognized as such late in the 19th century. The first recorded attempt directed toward surgical correction was carried out in Cardua in 1893. The surgeon attempted to do a jejunostomy but the patient died,—either on the table or very shortly thereafter. In 1898 Willy Meyer in this country and Stern in Germany each operated upon two patients with congenital pyloric stenosis. Gastro-enterostomy was done in each case and both of them died. During the years 1900 to 1904, Shaw and Elting⁴ reported 39 cases in which gastro-enterostomy was done and there were only 17 recoveries.

It is hard to realize that it has been only a few more than twenty-five years since Rammstedt and Fredet first advocated the

classical pyloromyotomy for congenital stenosis of the pylorus. It was in 1913 that Rammstedt carried out his first operation but for some reason or another did not report it until almost four years later. In spite of the good results obtained by the Fredet-Rammstedt procedure a "standard text" published in 1919³ recommended the following surgery for the relief of congenital pyloric stenosis.

"In this stenotic stage, gastro-duodenostomy in two sittings, if necessary, should be the operation of choice.

"At the first of these, slight fixation of the involved parts to the abdominal incision, opening of the duodenum, and insertion of a temporary catheter for purposes of direct feeding.

"After a proper interval, depending upon the patient's gain in nutrition and strength, an anastomosis between this opening in the duodenum and the stomach, either by the small button of Meyer or a modification of the Finney operation."

Until 1920 the mortality rate was 51 per cent in the reported cases in which gastroenterostomy was carried out, as compared to 24 per cent, during this same period, in the cases on which a Rammstedt pyloromyotomy was done. Today, in uncomplicated cases of congenital hypertrophic pyloric stenosis, the mortality rate should be and is below one per cent. This is obviously due to careful and adequate preparation before surgery, combined with present day anesthesia, attention to fluid and electrolyte balance rather than any gross change in technique.

Congenital Obstruction of the Duodenum and Small Bowel:—

There is little or no mention in these older texts of the fact that incomplete rotation of the cecum may produce partial or complete obstruction of the second and third parts of the duodenum. The following quotation is one of a very few that indicates the cecum might be abnormally located.

"Malpositions—The ascending colon may be found on the left side. . . ."¹

Apparently, the entity of duodenal obstruction from adhesions secondary to an incompletely rotated cecum was not recognized until relatively recent years.

Duodenal obstruction may also be caused by extrinsic single or multiple bands that may occlude the lumen. Duodenal atresia or congenital diaphragms in the lumen of

the duodenum may also obstruct the duodenum at any point.

"There may be stenosis or, more commonly, atresia at any point, often at many points. Obstruction is much more frequent in the upper than in the lower part of the small intestine. . . . The prognosis for successful surgical intervention is poor".³

This sentence, printed 30 years ago, foretold an entirely hopeless outlook for the infant with obstruction of the small bowel due to congenital atresia or diaphragms.

Today, all of the above conditions in the duodenum and small bowel are recognized before the child is beyond surgical help and a great majority of them are successfully corrected. This is particularly true in cases of incomplete rotation of the cecum with duodenal obstruction.

Omphalocele:

The following is a legend beneath a picture from a text in 1919³:

"Fig. 12—Case of Omphalocele admitted to the Babies' Ward of the Sydenham Hospital. A semiglobular tumor 4 inches in diameter and 2½ inches above the level of the body. The stump of the umbilical cord is seen to the left side of the tumor. Sterile gauze dressings were applied. After several weeks the mass gradually sloughed off and the wound closed."

Until the past several decades all of these children with omphaloceles were put aside in the Nursery and treated in a like manner. Probably the greatest impetus in the formation of the present concept of attempting surgical correction of an omphalocele immediately after birth was given by Ladd and Gross. Even though omphaloceles occur once in about 5000 births, an attempt should be made to correct them. In smaller omphaloceles in which the opening in the abdominal wall is below 6 cm. adequate closure of the defect will be accomplished fairly easily. The larger ones will tax the ingenuity of the surgeon. If the thin membrane, consisting of peritoneum and amniotic membrane, covering the extruded contents is unruptured, then skin closure over the mass may be carried out. This will prevent peritonitis which will follow in a very short time since the membrane becomes permeable to bacteria in a very few hours. When the peritoneal cavity enlarges enough to accommodate the extruded intestinal tract, then a secondary repair with layer closure may be done.

In the ruptured omphalocele larger

than 6 cm., skin closure over the extruded intestines may be the only means of covering the defect; however, this makes the secondary repair much more difficult since dense adhesions will form between the serosal surfaces of the intestines and the subcutaneous fat.

Hirschsprung's Disease:—

It is extremely interesting to observe the growth of this condition over the past 50 years.

In the 1901 text, there is the following:—

"The reported cases thus far are few in number, but have been observed both in infants (Hirschsprung, Mya) and in older children (Osler, Hughes). The prominent symptoms are two:—Obstinate constipation, which in most of the cases has continued from early infancy and is sometimes so severe that the patients have gone for two weeks without a movement of the bowels; and distention of the abdomen, which may be extreme."

"The treatment consists of abdominal massage and mild stimulating laxatives. It is important to correct the stagnation of fecal matter by daily injections of soap water. Surgical aid, such as resection of the intestine, may be demanded in the severe forms of the disease. An artificial anus has been suggested; this must be considered, however, as a temporary benefit only."

In 1910, in regard to the etiology of Hirschsprung's disease, it was stated that "dilatation of the colon and hypertrophy of the colon may be due to muscular weakness or a partial defect in the lower portion of the large intestine."³

Another mention of therapy is listed as: "While the exact nature of the neurological impairment in Hirschsprung's disease is not known, sympathectomy will often alleviate the symptoms."

About 15 years ago, we find the following notation: "The most encouraging innovation in therapy has been contributed by Wade and Royle, based on the view that autonomic imbalance is at the root of the disturbance."²

Accordingly, many surgeons became enthusiastic about lumbar sympathectomy. Actually, these infants improved markedly immediately after surgery; however, this was only temporary. In several months all of the infants were back to their original state and many were worse than before.

No further progress was made in surgical treatment of Hirschsprung's disease until the past few years. Swenson and his associates have brought out what is apparently the correct solution to this old problem. It is fairly well proved now that Hirschsprung's disease is secondary to partial, long continued obstruction. The mechanism responsible for partial obstruction is incomplete formation of the enteric plexi in the wall of the sigmoid and rectum. This results in a segment of lower sigmoid and rectum which has no organized peristaltic force. The fecal stream coming down from above arrives at this area and then stops since it is not picked up and propelled further. This results in hypertrophy and dilatation of the colon above this area, since there is the constant effort of the proximal colon to force the fecal stream past this point.

On roentgenological examination and at the time of surgical exploration a definite "transition area" can be demonstrated. This area marks the location of the end of organized peristalsis. In this region there is the segment that has incompletely formed enteric plexi and where organized propulsion stops.

Swenson and his associates advocated resection of the colon from above this level down to the pectinate line in the anus with anastomosis at this level. The surgical technique in this type of procedure has been adequately described in recent literature and has no place in this paper.

In Swenson's group and in our group, the results have been completely satisfying. Within 4 weeks after surgery the infant has normal daily bowel movements and radiological examination of the colon after six months shows that the proximal colon has returned to normal calibre. In

our group, there are a number of these cases in which surgery was done more than 18 months ago. At the present, they are normal infants, having spontaneous bowel movements daily and with no residual abdominal distention.

Apparently, pediatric surgery has finally solved a problem that was the cause for high infant mortality before ten years of age.

In a short paper of this type, some advances have to be omitted because of insufficient time; however, mention should be made of the treatment of tracheoesophageal fistulae and congenital cardiac problems. Overholt, Sweet and others have changed the problem of a tracheoesophageal fistula from a hopeless one into one of hope. Blalock, Potts, Gross, Johnson and others have improved cardiac conditions in the past few years. There is still much to be desired but at least concentrated work is being done.

In conclusion, we have touched upon a few of the pediatric surgical problems that have been recently solved. With the realization that Pediatric Surgery has just begun to grow, we who are interested in it look forward with enthusiasm to the next twenty-five years which will undoubtedly open up broader horizons and reveal remarkable advances in this "step-child" of surgery.

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The Present Status of Cardiac Surgery

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It is a considerable honor to be invited back to the state of Kentucky to take part in the centennial program of this great Society. The charter members of this Society founded it at a time when the whole field of surgery was ripe for development. The members of the Society have played no small part in that development. As you are now about to start on your second century of usefulness, perhaps it would not be amiss to call your attention to one of the branches of surgery which is even now ripe for development—namely, the surgery of the heart. I have therefore chosen to speak on the subject, "The Present Status of Cardiac Surgery." I shall attempt to point out the things which have already been accomplished and perhaps to call attention to some of the problems which are yet to be solved.

I shall discuss first those congenital conditions for which well-established operations are available: (1) patent ductus arteriosus; (2) tetralogy of Fallot; (3) pulmonary stenosis, and (4) coarctation of the aorta; then the acquired conditions which are now amenable to surgery: (1) mitral stenosis, and (2) chronic constrictive pericarditis; and finally, those conditions for which a solution is urgently needed.

Until comparatively recently most physicians and many cardiologists were content with a diagnosis of "congenital heart disease." As surgeons have become active in this field, however, it has become important to have an accurate anatomic diagnosis. The cardiologist experienced in this field can usually make a diagnosis of the common congenital lesions by the ordinary technic, namely the clinical examination, electrocardiography and fluoroscopy. In many instances, however, special technics must be used, such as angiocardiology, aortography and cardiac catheterization. Even then the diagnosis is not always exact. It is obvious that no

one individual can perfect the many techniques required in the diagnosis and treatment of these cardiac lesions. A team of several individuals interested in these problems is essential to any considerable success.

Patent Ductus Arteriosus

The ductus arteriosus normally becomes obliterated at or shortly after birth. When it remains open, the effect upon the patient depends upon the size of the shunt. When it is large, the individual may develop heart failure in infancy or childhood. When it is small, the patient may live to adult life without difficulty. On the average, the life expectancy before the days of antibiotics was about 35 years (1) (2), heart failure and subacute bacterial endocarditis being the most frequent causes of death. That figure would certainly be influenced somewhat by the effect of antibiotics on subacute bacterial endocarditis.

Compared to the risk of the lesion, the risk of operation is insignificant. Since the first operation by Gross in 1938 (3), many such operations have been done by a large number of surgeons. In all large series the mortality is low. In our own series there has been but a single death in 107 operations. That would seem to be a small risk for an operation which apparently increases the patient's life expectancy from about 35 years to the normal of 70 years.

We therefore feel that a patient with a patent ductus arteriosus should be operated upon as an elective procedure in the same manner as a patient with any other congenital lesion, without waiting for the complications to occur. The time of election for the operation is about four years of age. The operation is easily done then before the child starts to school. There should be no hesitancy in operating at an earlier age if the heart begins to increase in size. The risk is probably somewhat greater in adult life. The ages of our patients varied from 5 months to 46 years.

Preoperative Studies

The cardiologist experienced in this field can make the diagnosis of patent

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ductus arteriosus in most instances without the use of special studies. Even so, the surgeon depends upon him to pick up the occasional patient with a right aortic arch or some other associated anomaly. If there is doubt as to the diagnosis, cardiac catheterization or aortography will usually clarify the picture.

Surgical Technic

It is felt that the lateral approach allows one the safest exposure when operating upon the patent ductus arteriosus. A 4th interspace incision in children or a 5th rib incision in adults has proved satisfactory. The lung is held posteriorly and the mediastinal pleura is opened posterior to the phrenic nerve. The pulmonary artery is first exposed and the areolar tissue over the aorta is divided. The lung is then rotated forward and the angle between the aorta and the left pulmonary artery is increased. At the apex of this triangle is the ductus. With reasonable care the areolar tissue over the ductus and aorta may be removed. The recurrent laryngeal nerve is then found to go around behind the ductus and must not be injured. It has been our custom at this point to free the aortic arch sufficiently so that in the event of catastrophic hemorrhage, non-crushing Crafoord clamps could be placed across it on either side of the torn ductus. With this bit of insurance the dissection may then be carried behind the ductus to completely free it. If there is any doubt as to the extent of the ductus, one should not hesitate to open the pericardial sac if it seems that such a maneuver will be helpful.

The ductus may then be ligated or divided (4) depending upon the type. A good many surgeons divide all ducti as a routine. We have felt this to be unnecessary in most children who usually have long pliable ducti, and that three tightly tied silk ligatures may be depended upon to close the ductus. It is felt that the only reason for "recannulization" of a ductus is that the ligatures were not tied tightly enough. If one is prepared to divide the ductus in the event that the ligature cuts through, he does not hesitate to tie the ligatures as tightly as possible. It is our custom to divide the ductus in all adults since it is usually shorter and less pliable than in children.

In the division of the ductus the Potts' patent ductus clamps have been found to be most useful. They are designed not to

slip off. Even so, it is probably best to cut the ductus only halfway through and sew that part before cutting the rest. A simple over-and-over suture down and back of 5-0 Deknatel silk is used.

In the event that the clamp slips off the ductus or cuts through it, the surgeon should be prepared to use the Crafoord technic (5) of placing non-crushing clamps across the aorta above and below the ductus as well as on the pulmonary artery, so that the hole in the side of the vessel may be sutured in a dry field. If it is found to be impossible to close the aortic opening in less than 15 minutes, it is wisest to apply a Potts aortic clamp which will allow blood to go through the aorta while the opening in the side is being closed.

The surgeon who plans to operate upon even one patent ductus arteriosus should be prepared to use these technics in the event that a tear of the ductus should occur.

Results

Of the 107 patients operated upon, the only death occurred in the third patient at a time when we were not prepared to recover from a tear of the ductus. We have been able to recover from this complication on subsequent occasions.

We are aware of "recannulization" of the ductus in only one instance. This was in a right-sided aortic arch when we had poor exposure and the certain knowledge that if the ligature should cut through the ductus we were not in a position to recover. Most certainly the ligature was not tied tightly enough.

In the absence of other congenital abnormalities, the patient whose patent ductus arteriosus has been operated upon may be considered to be a normal individual.

Tetralogy of Fallot

In the tetralogy of Fallot the patient is cyanotic because unoxygenated blood from the right ventricle passes directly into the "overriding" aorta. This right-to-left shunt is increased by the presence of pulmonary stenosis, making it more difficult for the blood to go to the lungs. Although an occasional patient with this defect may reach adult life, most of them die in childhood.

The purpose of the operation, first done by Blalock (6) in 1944, is to increase the blood flow through the lungs. This is

done by a left-to-right shunt outside the heart to compensate for the right-to-left shunt inside the heart. In the Blalock (7) operation, the subclavian artery is anastomosed to the side of the pulmonary artery. The Potts (8) operation accomplishes the same thing by a lateral anastomosis between the side of the descending aorta and the left pulmonary artery.

The cardiologist must determine which patients in the cyanotic group have the tetralogy of Fallot and may be amenable to surgery. In the typical case, the diagnosis may be made without special techniques. In doubtful cases, the angiogram may be very helpful in showing the simultaneous filling of the pulmonary artery and aorta from the right ventricle.

The best age for operation is from four to twelve years. Many cyanotic children left alone will not live to the age of four years. We believe, therefore, that operation should not be denied these infants. The decision must be made on the basis of the child's general condition, the degree of cyanosis, the evidences of cardiac failure, and the degree of polycythemia.

Surgical Technic

In the presence of actual or impending heart failure, digitalization should be accomplished before operation. The patient should be kept well-hydrated to decrease the likelihood of thrombosis incident to the polycythemia. Heparin is not used unless there is evidence of thrombosis postoperatively.

Blalock performs the anastomosis between the subclavian branch of the innominate artery and the pulmonary artery. Holman (9) and Paine and Varco (10) have preferred to use the subclavian branch of the aorta. Our experience has led us to agree with Blalock, for even though the subclavian on the left seems adequate in length, it tends to kink at its origin from the aorta as it is turned down.

When the subclavian artery is found to be too short to reach the pulmonary artery, we have successfully used a vein graft to bridge the defect (11). However, since then, when dealing with a tall individual when some difficulty is anticipated, we have operated upon the side of the aorta. Then if the subclavian is too short to reach the pulmonary artery, a Potts operation may be done. If that is difficult because of an uncoiled aorta, a

piece of the subclavian may be used as a free graft between the aorta and pulmonary artery. On two occasions, when the left subclavian kinked as it was turned down from the aorta, we have used it as a free graft by anastomosing one end to the under-side of the aorta and the other to the side of the left pulmonary artery.

It has been felt that the Potts operation is simpler to perform in infants than the Blalock operation. It is usually preferred in children under 20 pounds, and has often been used in older children. The Potts operation had probably best not be tried on a right aortic arch in children over 20 to 30 pounds in weight. When we desire the anastomosis to grow with the child, we have used interrupted sutures on the anterior surface to decrease the probability of constriction at the anastomotic site (12).

When the pulmonary artery is absent or too small to use for an anastomosis, we believe that it is worth while to remove the parietal pleura and to sprinkle talc or asbestos powder over the lung. Several children have been definitely improved by this procedure, we believe, due to the development of a collateral circulation to the lungs.

Results

In this series there have been 21 Blalock operations and 49 Potts operations. No anastomosis was accomplished in 7 cases. The mortality of the entire series has been 12 per cent. There were but two deaths in 14 Potts operation on infants under 2 years of age.

In doing the Potts operation, it is difficult to be certain of a functioning anastomosis if an opening less than one-quarter of an inch is made. This is obviously a large anastomosis for an infant and may represent the diameter of the aorta. We have been concerned about the enlargement of the heart in some of these patients postoperatively. It is hoped that as the patient grows up, the heart may decrease in relative size.

While it must be realized that these operations do not make normal individuals of these patients, there can be no doubt that there is a tremendous improvement in most of the patients. The polycythemia decreases, the arterial oxygen saturation increases, and the exercise tolerance increases. Time alone will tell what the life expectancy will be.

Pure Pulmonary Stenosis

With a pure pulmonary stenosis, the patient is not cyanotic since there is no right-to-left shunt. Right ventricular hypertrophy results from the necessity of pushing the blood through the stenotic valve and eventually right heart failure with cyanosis may occur. If an interauricular septal defect is also present, cyanosis may be present from the start.

The Brock (13) operation provides a direct attack upon the stenotic valve. While the operation is performed inside the heart and is therefore a "blind" procedure, it can be performed with reasonable assurance of accuracy.

At operation a thrill can be felt in the pulmonary artery and can be felt to originate at the valvular area. Almost all instances of pure pulmonary stenosis are valvular in type.

Surgical Technic

An anterior incision is made through the 4th interspace and the 4th and 3rd costal cartilages are divided. An opening is made in the right ventricular wall between hemostatic sutures, and an instrument is inserted to confirm the diagnosis of pulmonary stenosis. A Brock valvulotome is then inserted to cut the valve and after that a dilator may be used. Although the procedure is a very short and simple one, the heart does not stand manipulation as well as in patients with the tetralogy of Fallot.

One should have various types of punches available in the event that an infundibular type of stenosis is found. Under such circumstances it is worth trying to bite out a bit of the muscular diaphragm causing the stenosis. One of our two patients appeared to be of this type.

Mr. Brock feels that this direct attack upon the area of stenosis should also be used upon patients with the tetralogy of Fallot. Most surgeons have reserved this operation for the patients with pure pulmonary stenosis, however.

Results

The results of operation are good. The amount of regurgitation produced does not seem to cause much trouble. This series includes only two such operations. Both patients have been improved.

Coarctation of the Aorta

Coarctation of the aorta is a congenital constriction of the aorta just below the origin of the left subclavian artery. Hy-

pertension develops proximal to the constriction, while the blood pressure in the legs may be low or unobtainable. Maude Abbott (14) found the average age of death to be 33 years. Death was due most often to complications of the hypertension, including actual rupture of the aorta.

The diagnosis is usually suspected because of the presence of hypertension in young individuals. It is readily confirmed by the low or absent blood pressure in the legs, the evidence of collateral circulation in the interscapular region, and the small aortic knob and scalloped ribs on chest x-ray. The defect may be shown by angiocardiology, but this is not essential for the diagnosis.

Crafoord (15) did the first operation for coarctation of the aorta in 1944. He placed non-crushing clamps across the aorta above and below the constriction, excised the constriction and brought the remaining ends together with a continuous silk suture.

Degenerative changes in the aortic wall increase the risk of operation. These are obviously more likely to occur in the older age group. It would seem important, therefore, to do the operation before such degenerative changes occur. The patients in this series have varied from 5 to 39 years of age. There can be no doubt that the operation is technically easier in the younger age group. When the operation is done in children, it is wise to use interrupted sutures so that the anastomosis may grow as the patient grows (16).

In freeing the aorta around the coarctation, special care must be taken not to tear the greatly dilated intercostal arteries. Some surgeons attempt to save all these arteries, while others divide them to facilitate the operation. If a successful anastomosis is accomplished, it probably makes no difference whether or not the intercostals have been sacrificed. If the anastomosis should fail, it would be better not to have destroyed the collateral circulation. We have attempted to save most of the intercostals and place the posterior row of sutures from the inside of the aorta, without rotating it.

It is frequently a matter of judgment as to how long a segment of aorta may be excised without creating too long a defect for safe end-to-end anastomosis. The elastic aorta of young patients is much more amenable to stretching than the

sclerotic aorta of older patients. When the defect is too long to be overcome by end-to-end aortic anastomosis, one may turn down the subclavian artery and do an end-to-end subclavian-aortic anastomosis; or a graft may be used. Every effort should be made to bring the aortic ends together, because the subclavian anastomosis is certainly not as likely to be successful. Of four such operations in this series, only two had a satisfactory decline in blood pressure.

Gross (17) and others have used "preserved" aorta homografts to bridge the defect in the aorta, when long areas of constriction have been encountered. There is evidence that these grafts undergo degenerative changes and are replaced by host tissues, but they appear to serve their purpose successfully. If it becomes necessary to use a graft in a child, it may be best to use an autogenous vein graft. There is experimental evidence that aortic homografts are not likely to grow, whereas vein autografts do grow (18). The author is not aware of a clinical trial of an autogenous vein graft for coarctation of the aorta at the present time.

Results

Immediately after operation, there should be good pulses in the lower extremities, and the blood pressure should be higher in the lower extremities than in the upper. If this is true, the surgeon can be assured that he has made a large enough anastomosis and that the systemic blood pressure will fall toward normal in due time. When the pressure in the lower extremities is still slightly lower than in the upper extremities immediately after operation, the result may still be good. The fall in pressure may require as long as two to three weeks to occur. The reason for this is not completely understood.

The mortality of this operation is low considering the nature of the procedure. The only death in this series of 26 patients was due to the degenerative changes already present in the aorta of a 24-year-old patient who carried a blood pressure of 260/140. Obviously the risk will remain higher in the older age-group because of degenerative changes in the aorta.

It is too early to know the late results of this operation. It is anticipated, however, that patients in whom the blood pressure returns to normal should have a normal life expectancy.

Mitral Stenosis

More than 25 years ago Cutler and his associates (19) and (20) attacked the problem of mitral stenosis by punching out a segment of the stenotic valve. This allowed considerable mitral regurgitation so that the mortality was prohibitive. In recent years the effort to correct mitral stenosis has been revived by Bailey et al (21), Harken (22) and others. Bailey thought that if the mitral valve could be opened along the fused commissures without removing any of the valve, little if any regurgitation would result. This has proved to be correct. The stenotic mitral valve is often thickened by disease for only a few millimeters from its edge. If this thickened portion is cut through in the line of the fused commissure, the valve may function again relatively normally.

Preoperative Evaluation and Preparation

In general, it is felt that any patient with mitral stenosis of sufficient severity to materially alter his activity should be operated upon if there is no contraindication. The patient apt to get the best result is one who has little if any systolic murmur. When bouts of pulmonary edema have been experienced rather than right heart failure, the patient will probably respond more quickly to correction of the stenosis.

Factors which tend to contraindicate surgery are: (1) right heart failure which cannot be overcome by medical means (23); (2) marked mitral regurgitation; (3) other severe valvular or myocardial disease; and (4) continued activity of the rheumatic fever.

The patient should be treated medically until out of heart failure if it is present. If the patient has not been in failure and is not fibrillating, digitalis is not given routinely. If he is fibrillating, the rate must be controlled.

Operative Technic

In this series most of the patients have been anesthetized about as any other thoracic surgical patient. Pronestyl has also been used to decrease the tendency toward ventricular fibrillation during the cardiac manipulation.

The patient is supine with a sandbag under the left side. A 4th interspace incision is used, but carried back to give good exposure. The 4th, 3rd and perhaps the 5th cartilages are cut. The pericar-

dium is opened either in front of or behind the phrenic nerve.

A purse-string suture is placed around the auricular appendage, a non-crushing clamp is applied and the tip of the appendage excised. As the clamp is released, the finger may be inserted into the auricle, blood loss being prevented by tightening the purse-string suture around the finger.

The location and size of the valve opening may then be noted and the amount of regurgitation, if any, estimated. One may then attempt to tear open the commissures ("finger fracture") or cut them with the Bailey guillotine knife. In our hands there has been less regurgitation produced by "finger fracture" than by the knife, probably due to the difficulty of placing the incision exactly where it should be. In some patients the guillotine knife must be used because of the thickness or calcification of the valve. Protection of the auricle from the knife handle is afforded by the operator's wearing a second glove on the right hand with the knife emerging at the tip of the finger.

The original efforts in the hands of others at cutting the posterior medial commissure were disastrous due to regurgitation, so that for some time our efforts were confined to the anterolateral commissure. Often, however, the valve opening is situated so close to the anterolateral wall that an adequate opening cannot be obtained there. More recently, following Harken's advice, we have found that by attacking the posteromedial commissure first, it may often be opened with the finger, this to be followed by opening the anterolateral commissure.

The other problem of concern has been that at times the neck of the auricular appendage is so small as to be in danger of tearing as the finger is inserted. Adding the guillotine knife under such circumstances increases that danger somewhat.

Results

There can be no doubt that mitral commissurotomy as now practiced is a worth while operation. Of the 27 patients operated upon six died. We have reason to hope that this mortality rate may be reduced and that some of our early mistakes may not be repeated. Of the remaining 21 patients 15 were significantly improved. Six of these were tremen-

dously improved and are now living relatively normal lives. Six have received only minimal improvement. It is felt that in most instances the degree of improvement depends upon the success of producing a functioning opening in the mitral valve without significant regurgitation. It is believed that since we now attack the posteromedial commissure first and then the anterolateral commissure, that a higher percentage of the patients will be greatly improved by the operation in the future. Once the technical problems are mastered, most of the mortality may be expected to be in desperate-risk patients.

Chronic Constrictive Pericarditis

This was one of the earlier cardiac lesions submitted to surgery. The problem is simply that of removing the thick, diseased pericardium which is constricting the heart and preventing adequate filling of the heart. The components of the classical diagnostic triad are: (1) a small, quiet heart; (2) a low pulse pressure; and (3) an increased venous pressure. At times, however, it takes the best of cardiologists to evaluate the part played by constriction by the pericardium as compared to a failing myocardium.

In the preoperative preparation, it is important to get the patient as free of retained fluid as possible.

Operation

The treatment of chronic constrictive pericarditis is the removal of enough of the thickened pericardium to allow free expansion of the heart. In the not too distant past this procedure was done under local anesthesia with an incision that did not open either pleural cavity. The amount of pericardium which was removed was small but the bony structures of the anterior chest wall were also removed so that the patient usually showed marked improvement.

More recently, the heart has been exposed through the left chest, with a fifth interspace incision and cutting of the fifth, fourth and possibly the third costal cartilage. A large area of pericardium may be removed from the left side of the heart. This resection may extend from the pulmonary veins on the left to the midline anteriorly. In our experience such an operation has always been adequate. At the time of operation, however, the surgeon is tempted to continue the excision of the pericardium beyond the exposure allowed by the chest wall incision. In

the freeing of the adherent pericardium from the myocardium, the surgeon should have good exposure and good lighting, not only to decrease the risk of tearing into the cardiac cavity but also to increase the chances of recovery from such a situation if it should occur.

Holman (24) has stressed the importance in some patients of removing the pericardium on the right side of the heart. Churchill (25) and others (26) have pointed out the importance of constriction around the pulmonary veins on the left side. In order to get wide exposure of both sides of the heart, we (27) have used a transverse incision in the 5th interspace traversing the sternum. It extends from the mid-axillary line on one side to the mid-axillary line on the other, and allows excellent exposure. We have used it only in our good-risk patients to date. In the poor-risk patients, only the left side of the incision is used, with the thought that the right side could be done at a second stage if necessary. To date that has never been necessary, the left-sided decortication having been adequate in all instances.

The postoperative care of these patients must be as meticulous as the operation itself. Intravenous overhydration should be strenuously avoided. Digitalization is usually continued and mercurial diuretics are often indicated.

Results

In the last five years we have performed pericardiectomy on thirteen patients with constrictive pericarditis, with only one death. That was a patient in very poor condition in whom we made the mistake of attempting to free the pericardium beyond the bounds of the chest wall incision, and were not in a position to recover when the cardiac cavity was inadvertently entered.

One patient was operated upon by excision of the bony chest wall without entering the pleural cavity. Five have been done by the transverse bilateral incision, and seven were done by the left thoracotomy incision.

All of the patients except the one who died did well after operation and were relieved of constrictive pericarditis. One died quite suddenly three months after operation, without an autopsy. The others are living relatively normal lives and are believed to be free of cardiac constriction.

Problems Not Yet Solved

We have as yet barely scratched the surface of cardiac surgery. Many problems remain to be solved.

The interauricular septal defects and interventricular septal defects are purely mechanical problems which must be solved. Present methods appear to be inadequate. It seems likely that we must first perfect the machine for the maintenance of an extracorporeal circulation. Then the heart may be opened and these defects closed with some deliberation. That such an apparatus will be perfected I believe I can assure you beyond any reasonable doubt.

The repair or replacement of badly diseased mitral valves may be possible, for many of them are too badly diseased to help by present technics.

Aortic stenosis is another purely mechanical problem which has not been solved to date. Whether it will be necessary to make entirely new valves or whether the old ones can be rebuilt is not yet clear.

Once the heart-lung apparatus is perfected, the attack upon the tetralogy of Fallot will be a direct one. It may also be possible to reverse the position of the great vessels in the cases of transposition.

The problem of coronary artery disease is still with us, in spite of many years of work by excellent investigators. None of the various methods of producing increased blood flow to the myocardium have become widely accepted. Beck's (28) recent work on reversing the blood flow through the myocardium by shunting arterial blood into the coronary sinus must still be considered experimental.

That many of these problems will be solved, there can be no doubt. Surely we must look to imaginative investigators for these accomplishments—young men of vision and industry.

Summary

(1) It is recommended that the patient with a patent ductus arteriosus be operated upon as a prophylactic measure. The age of about four years appears to be an excellent time for the procedure. If no other deformity is present, the patient will be normal thereafter. The risk is about 1 to 2 per cent. The operation may be done at any age when necessary.

(2) Most patients with the tetralogy of Fallot are tremendously improved by any operation which shunts more blood into the lungs. Although the optimum age for operation is from four to twelve years, it is often necessary to proceed at an earlier age.

(3) The patient with pure pulmonary stenosis should be operated upon by the Brock procedure before the development of heart failure. The risk is small and the results good.

(4) The operation for coarctation of the aorta should be done as an elective procedure to avoid the complications of hypertension. The mortality will be especially low if the operation is done before degenerative changes occur. The age from 8 to 12 years is recommended. If an adequate anastomosis is done before irreversible changes occur, the patient should have a normal life expectancy.

(5) Commissurotomy for mitral stenosis has proved its worth and may now be considered to be an established operation. Many patients may be tremendously improved by the procedure. The mortality may be expected largely in desperate-risk patients.

(6) Adequate excision of the diseased pericardium may be expected to give prompt relief to the patient with constrictive pericarditis.

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Deafness—Its Present Day Management

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The specialty of otolaryngology has undergone a significant metamorphosis since I completed my graduate training in 1937. But rather than representing a regression with relation to the broader medical field, the newer concepts and special technics developed in our specialty in the past 15 years represent real progress. The void created by the control of most acute surgical infections by specific drug and antibiotic therapy has been filled by a better understanding of allergic processes, more attention to plastic surgical procedures and last, but not least, a more positive approach to the great problem of deafness. The development of the endaural one-stage fenestration technic by Lempert¹³ in 1938 ushered in a new era in otology. Selection of cases suitable for surgery necessitated more accurate diagnostic testing technics. This, in turn, proved to be a definite impetus to providing more adequate rehabilitation for those not suited for fenestration. The program developed by the Army and Navy for rehabilitating the deaf supplied additional knowledge which has been of immense value in managing the deafened individual.

This discussion will be concerned chiefly with the chronic form of deafness because time will not permit consideration of the acute lesions. Particular emphasis will be placed on otosclerosis, prenatal diseases which may influence hearing and the nerve type of deafness designated as hydrops of the cochlea.

Recent advances in otologic surgery¹⁶ enable the otologist to handle more successfully the problem of congenital atresia of the external meatus both as to the restoration of serviceable hearing and the cosmetic result. However, the occasional anomalous position of the facial nerve introduces an element of hazard as far as this structure is concerned.

Central perforations of the tympanic membrane with a dry middle ear are quite amenable to closure treatment. The method which I have found to be most

satisfactory is the one originally described by Lynn with modifications suggested by Derlacki³. The essential steps are as follows:

1. Cauterize the margin of the perforation with saturated solution of trichloroacetic acid on a very small cotton tipped applicator.
2. Place a small piece of cotton dusted with sulfadiazine against the entire drum.
3. Moisten the cotton with several drops of 5% urea in saline.
4. Press the moistened cotton firmly against the drum.
5. Have the patient instill 3 or 4 drops of 5% urea solution twice a day. (Use a weaker solution if irritating.)
6. Repeat this treatment every week or two.

Perforations up to 5-6 mm in diameter can be healed. The number of treatments varies from 2 to 50 or more. Hearing improvements of 10-20 decibels are frequently obtained. It has been possible to close approximately 70% of properly selected central perforations by this technic. Persistence and patience are essential in the more obstinate cases.

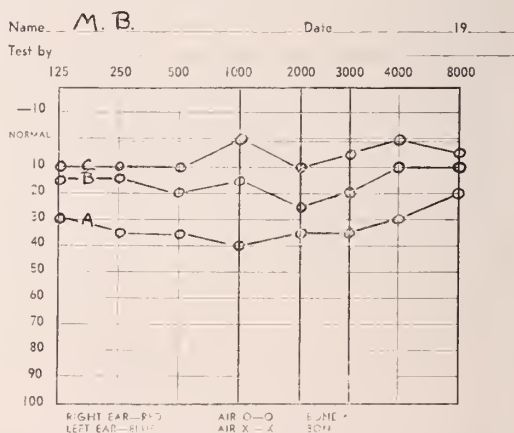


Fig. 1. A: Initial test on ear with perforation; B: Paper patch over perforation; C: Test after perforation healed.

Figure I shows the air conduction audiometric curve on an ear with a central perforation before treatment, with a paper patch applied and the perforation healed. Approximately a 30 decibel gain was obtained. This patient had bilateral perfor-

ations and both ears showed the same degree of improvement. The application of a paper patch over the perforation at the time of the initial examination will indicate whether a hearing improvement can be anticipated by closing the perforation.

Another method of closing perforations is by cauterizing the margin and applying some form of patch, i. e. cigarette paper, cellophane or Cargile's membrane. In my experience this has not been as satisfactory as the other method just described.

In some ears with perforations which cannot be healed, a useful improvement in hearing can be obtained by the use of a small soft rubber prosthesis. The layman usually refers to this as an artificial eardrum. The most satisfactory one in my opinion is the Way drum.* The patient must be instructed concerning its insertion and removal as there is a tendency for the ear to drain at times. Suitability as to the use of this prosthesis can be determined by the acoustic probe as described by Pohlman^{17,18}.

Perforations involving the margin of the tympanic ring cannot be closed. Attic retraction perforations with cholesteatoma should be treated surgically. The usually good hearing in such cases can be preserved if a modified radical (Bondy) mastoidectomy with preservation of the tympanic cavity is done. If surgery is postponed too long the cholesteatoma may invade the middle ear and as a result the hearing will be greatly impaired permanently.

Chronic secretory otitis media (serous otitis media) not infrequently presents a challenging problem. In less severe cases myringotomy and removal of the fluid from the tympanic cavity by inflation and aspiration suffices. In some instances this may need to be repeated a few times. In the more obstinate cases, however, further investigation is necessary. Thorough study of these usually reveals an allergic basis. If the allergy can be readily controlled the ear will promptly return to normal. Radiation therapy to the nasopharynx has in general been disappointing in these cases. Another cause of unilateral secretory otitis media is carcinoma of the nasopharynx. A thorough inspection of the nasopharynx is imperative in every case of fluid in the middle ear.

Effective management of excessive and pathological lymphoid tissue in the nasopharynx of children is still not a solved problem. Several years ago the general introduction of the nasopharyngeal radium applicator was hailed as the final answer to controlling this tissue. However, critical and long range evaluation of the efficacy of nasopharyngeal radiation therapy has not substantiated the original enthusiasm concerning its value. At the present time the emphasis is again on more thorough surgical adenoidectomy with particular emphasis on the consideration of allergic factors in those instances where a tendency toward recurrence is observed. Radiation is now used more as an adjunct to other therapeutic measures in properly selected cases. The following case illustrates this most satisfactorily.

D. P. Age 13

History

Since infancy has been subject to frequent colds and marked fluctuations in hearing. Earache with drainage a few times. Had T and A at the age of 7 and re-adenoidectomy at 9. No appreciable benefit from these two procedures.

Examination

Nose—mucosa somewhat pale.

Tonsils—out.

Nasopharynx—scattered lymphoid follicles. Small adhesive bands in Fossae of Rosenmuller.

Ears—Tympanic membranes thick and retracted, somewhat more on the left.

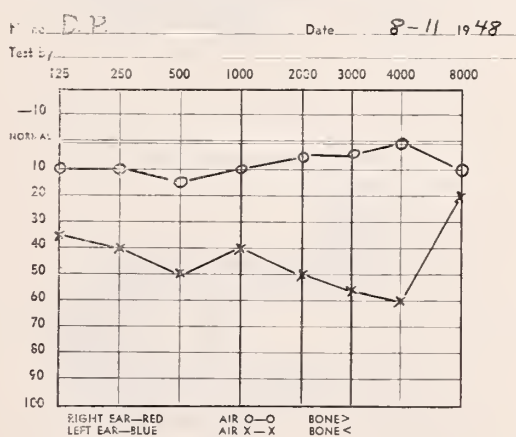


Fig. 2. Initial audiogram. There was probably fluid in the left tympanic cavity.

Figure 2 shows the audiogram at the time of the initial examination.

He was given two series of treatments with the nasopharyngeal radium appli-

*Manufactured by the Surgical Division of the American Optical Co.

cator together with digital breaking down of the adhesive bands in the Fossae of Rosenmuller. Very little relief was obtained. Allergic investigation revealed positive reactions to dust and moulds. Desensitization produced prompt improvement and a normal stable level of hearing has been maintained.

I have observed other instances in which control of an obviously allergic rhinitis resulted in definite regression of excessive nasopharyngeal lymphoid tissue. Excessive intake of carbohydrates with the resultant deficiency for other dietary requirements is a contributing factor in some children.

Otosclerosis

The greatest advance in modern otologic surgery has been Lempert's contribution in 1938 of the one-stage endaural fenestration technic for restoration of serviceable hearing in clinical otosclerosis^{13a, 13b} (Fig. 3 and 4). Shambaugh^{20,12}, House¹⁰ and others have made added improvements in technic which have greatly enhanced the chances of obtaining a permanently successful result.

Otosclerosis manifests itself clinically when the otosclerotic process involves the



Fig. 3. Normally, sound reaches the inner ear through the ossicular chain as indicated by the arrows.



Fig. 4. The otosclerotic process (A) has fixed the stapes. A fenestra has been made in the lateral semicircular canal and covered by a skin flap at B. Sound now enters the inner ear through this surgically created window. The incus and head of the malleus were removed in carrying out the surgical technic.

footplate of the stapes and produces a conduction type of deafness (Fig. 4). In a small percentage of cases the process also involves the cochlea and a variable degree of nerve degeneration will be associated with the conduction lesion. Guild's⁶ histological study of temporal bones indicates that for every case of otosclerosis manifested clinically by fixation of the stapes, there are eight with histological lesions which are silent because neither the stapes nor the cochlea is involved. This has complicated the studies of the influence of heredity on otosclerosis and makes the elimination of otosclerosis on a eugenic basis impossible.

Heredity is in all probability the most important single factor in the etiology of otosclerosis. The otosclerotic process may be accelerated by pregnancy, infections or other sudden stress of the metabolic or endocrine balance. Recent studies by Allen¹ and Smith²² indicate that in 50% of pregnancies in otosclerotic women the deafness will increase somewhat. Clinical otosclerosis is no longer an indication for terminating pregnancy.

The belief that environmental differences in identical twins may influence the activity of an otosclerotic process is suggested by the fact that a few sets of identical twins have been reported in which one twin developed deafness and the other one did not¹¹. However, most identical twins with a hereditary predisposition develop clinical otosclerosis simultaneously.

The patient ideally suited for fenestration is the one with good cochlear function and complete or nearly complete fixation of the stapes (Fig. 5). The presence of good cochlear function is indicated by good acuity for bone conducted sound as determined by tuning fork tests and bone conduction audiometry. Complete fixation of the stapes produces a 50-60 decibel loss for pure tones on air conduction audiometry and a definitely negative Rinne for the 1024 frequency tuning fork. A negative Rinne with the 1024 tuning fork is essential if a substantial improvement in hearing is to be expected. However, to attain a good threshold by air after surgery the preoperative bone conduction threshold must be normal or near normal. The best air conduction threshold obtainable after surgery is usually 20 decibels below the preoperative bone conduction level (Fig. 6). The Eustachian tube should be patent. A small percentage of patients with clinical otosclerosis will

manifest calcareous deposits in the tympanic membrane or thickening as a result of otitis media in childhood. This does not contradict suitability for surgery if the hearing tests indicate good cochlear function. A perforation of the drum is a contra-indication for surgery. However, if the perforation can be closed surgery may be done.

Eighty per cent of those ideally suited for fenestration can, after surgery, expect to maintain a permanent hearing improvement sufficient to be equal to or better than the over-all help which could be obtained by the use of a hearing aid¹². The term permanent is used here to indicate at least a two year follow-up. Only occasionally will a patient show a decrease in a hearing improvement which has been maintained as long as two years after fenestration.

In the evaluation of cases of clinical otosclerosis as to suitability for fenestration, the presence of some associated nerve degeneration decreases somewhat the chance of obtaining a practical level of hearing. Those with considerable nerve deterioration should not be considered for surgery. (Fig. 7) The use of a hearing aid should be advised in these cases.

Nerve Deafness

Nerve deafness in general presents a rather dismal picture as far as restoring hearing is concerned. However, the expanding programs for rehabilitation of the severely or completely deafened have made it possible for most of these unfortunate people to become self-sufficient and reestablish for themselves a proper place in a hearing society.

Many individuals with a moderate degree of nerve deafness can wear a hearing aid with definite benefit. Adequate testing with pure tone and speech audiometry enables the otologist to advise the patient as to whether a hearing aid will be of sufficient value to warrant its use. Lip-reading, auditory training and speech training are of particular value in the more severely deafened.

The following is a classification of nerve deafness based chiefly on etiology:

A. Congenital

1. Endogenous—true hereditary influence based on a genetic defect.
2. Exogenous—prenatal influence of diseases such as Rubella, kernicterus from Rh factor.

B. Primary—etiology not established.

C. Secondary

1. Toxic—i. e. drugs, mumps, measles or other infections.
2. Allergic—i. e. serum reaction.
3. Acoustic trauma.

D. Presbycusis.

E. Hydrops of the cochlea.

Congenital

When a child is found to have an irreversible hearing defect, the inevitable question in the parents' minds is whether the lesion is hereditary. No one likes to be put in the position of being of inferior stock. If a history can be elicited indicating that the deafness is the result of prenatal Rubella or an Rh incompatibility, the exoneration of a possible genetic defect is some consolation in an otherwise tragic situation. Myklebust¹⁵ was the first to apply the terms endogenous and exogenous to congenital deafness.

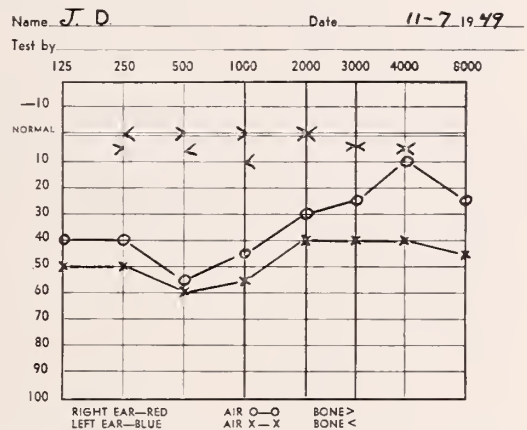


Fig. 5. Good cochlear function indicated by normal bone conduction threshold. The 1024 Rinne was negative in the left ear. The right ear shows incomplete stapes fixation.

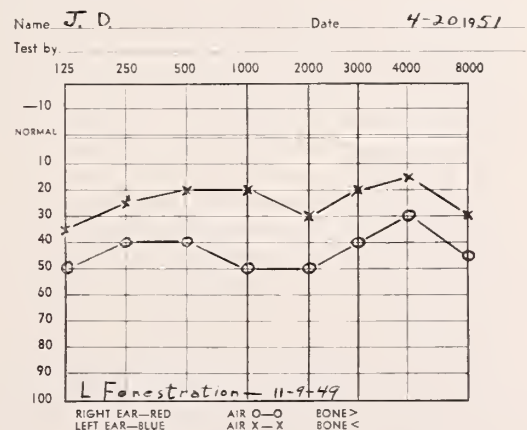


Fig. 6. Audiogram 1-1/2 years after fenestration on patient J. D. (see Figure 5). A good level of hearing has been maintained. The deafness in the unopened ear has increased due to further fixation of the stapes.

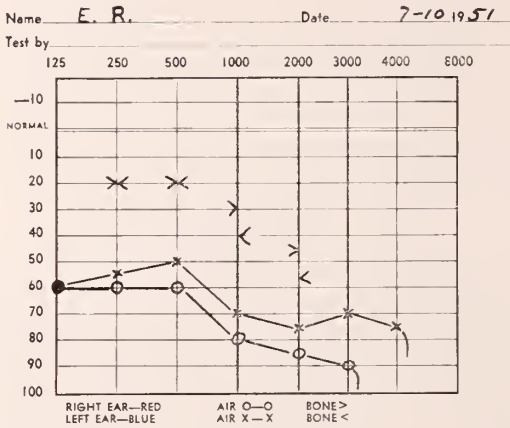


Fig. 7. Considerable cochlear degeneration is indicated by the bone conduction threshold being much below normal. A negative 1024 Rinne is present. The best level which could be produced by a fenestration on the right ear would be about 50 decibels. This would not be of any practical value to the patient.

1. ENDOGENOUS—These are the cases of congenital deafness which are truly hereditary and are based on a defective gene. A thorough family history will usually uncover other instances of similar lesions.

2. EXOGENOUS—This term implies that the etiological factors came from without the fetus and a hearing defect developed in spite of good genetic influence. Rubella² in the mother during the first trimester of pregnancy is an example. Other congenital lesions such as cataract and cardiac anomalies may be associated with this type of deafness. It is believed that those structures in the most formative stage at the time of the Rubella attack will manifest the greatest maldevelopment. Considering the termination of pregnancy in such cases has been advised by some. Histological studies of the temporal bones of fetuses so obtained have been reported by Schall¹⁹. The sections suggested that vascular damage may be the primary change which in turn produced arrest of development. Clinically these cases not infrequently have some residual islands of hearing which can be utilized in the process of rehabilitation.

In an analysis of 900 cases of profoundly deafened children, Goodhill⁵ found that in 166, or 18%, a history of maternal rubella in the first trimester of pregnancy was obtained.

Another cause of congenital deafness not on a direct genetic basis is the jaundice resulting from Rh incompatibility. The lesion here is thought to be a toxic one involving the ganglia of the brain stem and is called kernicterus. Goodhill⁵

studied a group of 101 cerebral palsied children and found deafness present in about a third of the 41 classified as the athetoid type. Most of these deaf cases had a history and laboratory evidence of erythroblastosis fetalis.

Rehabilitation and special education for children with congenital deafness should be started in the pre-school period. The John Tracy clinic in Los Angeles and the Volta Bureau in Washington can supply instructions and guidance for parents faced with such a problem. It is generally deemed more desirable to keep profoundly or completely deaf children in a normal home environment if appropriate special educational facilities are available in the local school system.

Primary Nerve Deafness

Under primary nerve deafness are included those cases of acquired nerve deafness for which no definite etiology can be established. As our knowledge of deafness increases the number of cases falling into this group is gradually becoming smaller. Enthusiastic reports of effective treatment of some of these cases with Vitamin A, Vitamin B and other preparations have been made by some otolaryngologists, but a critical application of identical therapy by others has proven to be disappointing. While therapy for early end-organ lesions might be beneficial in some instances, it is illogical to expect any regeneration of a partly degenerated organ of Corti.

In our present state of knowledge the most satisfactory management of these cases is the use of appropriate rehabilitation measures when the degree of deafness reaches a loss of 40 decibels or more. The use of speech tests to determine the patient's ability to understand amplified words is a great help in evaluating the effectiveness with which a hearing aid can be used. Lip-reading should always be a supplementary measure in these cases. Auditory training is helpful in the more profound cases as it teaches the individual to use more effectively his residual hearing. If there has been a deterioration in the quality of the speech, appropriate speech training is helpful.

Secondary Nerve Deafness

This includes those cases of nerve deafness which, on the basis of the history, are the result of a specific etiology.

Mumps occasionally cause a sudden complete loss of hearing. Fortunately the

loss in the majority of instances is unilateral. The loss is usually complete in the involved ear and there is no therapy. Measles and perhaps influenza can produce a similar lesion.

Drugs which may cause a loss of hearing include quinine, streptomycin, salicylates (rare). Tinnitus usually precedes the loss of hearing and its onset should be a warning to observe the hearing closely and modify the therapy accordingly. The recent experimental work of Glorig and Hudgins⁴ has shown that the crystalline form of streptomycin is much less toxic than the amorphous form.

The administration of serum has been reported to produce sudden severe loss of eighth nerve function. Such a lesion should be promptly treated by antihistaminics and intravenous procaine drip. Delaying therapy for a day or two may result in irreversible damage to the organ of Corti. The lesion here may be similar to that of labyrinthine hydrops.

Acoustic trauma manifests itself by tinnitus and a drop in acuity at the 4096 frequency level. Early avoidance of further exposure or protection by suitable ear plugs usually results in a return to normal. However, if exposure is continued, the hearing loss increases by spreading to the adjoining frequencies and becomes irreversible. The susceptibility to trauma is extremely variable in different individuals.

Presbycusis

Presbycusis is that deterioration of hearing which is the result of the process of aging. The audiometric curve shows a slightly greater loss for the higher frequencies than for the low. The ability to understand speech is usually somewhat less than would be anticipated from the minor pure tone loss which is seen early in these cases. The age of onset of this condition is variable. It begins in an insidious manner in the fifth or sixth decade. The site of the lesion in presbycusis is undoubtedly central as well as in the eighth nerve ganglia and hair cells of the organ of Corti. There is no medical therapy. The rehabilitation measures discussed under primary nerve deafness apply here. However, some older individuals with advanced presbycusis have difficulty using a hearing aid. Proper psychological management, stressing in particular the limitations of hearing aid use, is extremely important in these cases.

Labyrinthine Hydrops

A fuller understanding of this clinical and pathological entity has signalled a notable advance in our general knowledge of inner ear lesions. The literature on this subject is now voluminous and no attempt will be made to review it. The first histopathological description of the nature of Meniere's syndrome was made by Hallpike and Cairns⁵.

They found on histological study of temporal bones removed from cases of paroxysmal vertigo with tinnitus and deafness that there was marked distention of the membranous labyrinth. These observations have been verified by others. Cases of Meniere's syndrome are now usually considered to be due to hydrops of the labyrinth.

Observations on the hearing in cases of Meniere's syndrome indicated that in most instances a rather characteristic picture was found which was somewhat different from that observed in most other types of nerve deafness. When Meniere's syndrome developed in an ear with previously normal hearing, the loss was usually greater for the low tones than for the high. Tinnitus was chiefly of the low pitched type. A given pure tone was usually interpreted as having a higher pitch in the involved ear as compared with the normal ear. This is called diplacusis. Early in the course of the disease the hearing acuity decreased at the time of the attack of vertigo and returned to a variable degree during the intervals. There was, however, a tendency for less recovery to take place after each subsequent attack.

Careful study of cases of nerve deafness without vertigo²⁴ revealed occasional instances of fluctuating impairment with greater loss for the lower tones, low pitched tinnitus and diplacusis. It is now generally agreed that these are cases of hydrops of the cochlea without vertigo.

The specific etiology of this condition is still not definitely known. Autonomic instability is most commonly accepted as the basic physiological disturbance^{8,23}. Vasomotor imbalance involving chiefly the arterial supply of the labyrinth is thought to produce increased capillary permeability with the resulting increase of effusion of fluid into the endolymphatic space. Hilger⁸ has postulated that the clinical picture produced is dependent on the portion of the circulatory bed of the

labyrinth involved in the circulatory crisis. The artery which supplies the inner ear has no collateral circulation. If the entire labyrinthine circulation is disturbed, both vertigo and deafness will be manifested and the patient is described as having Meniere's syndrome. If only the arterial segment to the cochlea is involved, then cochlear symptoms alone will be elicited. The sudden onset of symptoms is considered to be due to an abrupt vasospasm. Hilger has formulated the concept that the vasospastic reaction may be the result of any one, or a summation of two or more of the following factors:

Emotional reactions

Sudden changes in physical environment

Inhalant or food allergy

The autonomic balance may be further rendered more unstable by fatigue, smoking and excessive use of stimulants such as coffee.

Medical therapy is directed largely toward release of the vasospasm as soon as possible by vasodilating drugs such as intravenous procaine with a small amount of nicotinic acid added or by intravenous histamine. Five per cent dextrose may be used as the diluent. Between and after intravenous infusions vasodilation should be maintained by oral administration of nicotinic acid, roniacol or similar drug. Hilger feels that it is extremely important to give proper consideration to the emotional background of these individuals and correct as much as possible any psychosomatic aspects of the picture. Tobacco and the use of excessive stimulants such as coffee and undue fatigue should be avoided.

The following cases illustrate hydrops of the cochlea of relatively sudden onset with a substantial return of hearing on medical therapy:

Sr. L., Age 40.

History—Hearing impairment in both ears for 5 weeks.

Onset *sudden*. Low pitched tinnitus.

No significant vertigo.

Examination—Drums normal. Eustachian tubes patent.

Rinne tests—positive, Schwabach tests shortened.

Audiogram Figure 8.

Treatment—Dilute Histamine.

Salt-free diet with KCl.

Progress—Improvement gradual. (Fig. 9).

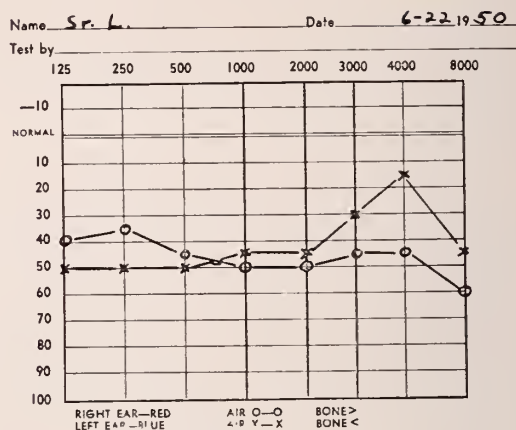


Fig. 8. Initial audiogram.

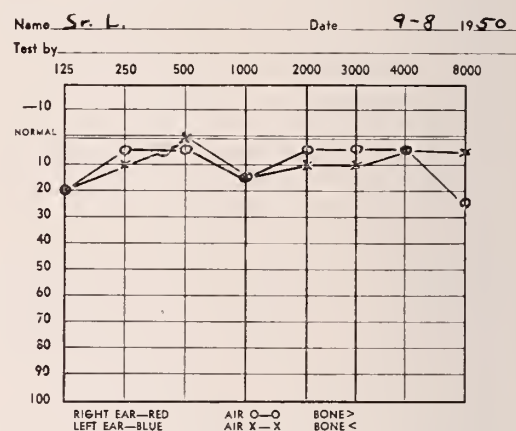


Fig. 9. Audiogram after three months of treatment.

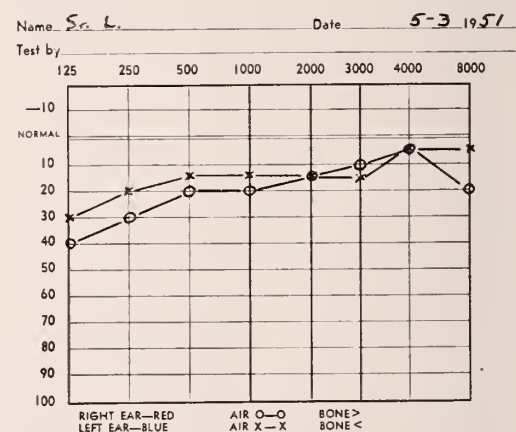


Fig. 10. Audiogram after pneumonia. More fluctuations noted since.

Patient had pneumonia after hearing had returned nearly to normal and following this there was a slight drop in hearing and a tendency toward more fluctuations. (Fig. 10).

C. J., Age 64.

History—L. ear—Gradual loss of hearing over a period of several years. Some attacks of vertigo at the onset of deaf-

ness. None recently.

R. ear—Deafness first noted on waking in A. M. ten days before examination. No vertigo.

Examination—Drums normal. Eustachian tubes patent. Rinne tests positive. Schwabach shortened for all forks. Audiogram showed a 50 decibel loss in both ears.

Treatment—Dilute histamine.

Salt-free diet and KCl.

Progress—The return of hearing in the right ear was gradual, beginning two months after treatment was started. There was no improvement in the left ear.

In the light of Hilger's recent observations it is probably preferable to give these patients a few intravenous infusions of histamine or procaine and then to follow with therapy such as these two patients received.

Specific food or inhalant allergy is occasionally a factor and should be given due consideration in evaluating the total clinical picture. I have seen a few instances in which apical dental abscesses were important. Any psychosomatic disturbances should be corrected.

While not related to the subject of deafness, I believe it will be worthwhile to refer to another concept proposed by Hilger⁸ concerning the nature of Bell's palsy. He feels that the etiology of this condition is a vasospasm involving the arterial supply to that portion of the nerve which traverses the Fallopian canal. The common history of chilling preceding the onset of the paralysis in many cases would be the environmental stress which initiated the local vasospastic reaction. Loomis¹⁴ reported treating several cases by intravenous histamine with amazingly rapid recovery. Skinner²¹ reported similar prompt response to a more dilute dosage. Obviously the best results will be obtained if vasodilating therapy is started as soon as possible after the onset of the paralysis. Once degenerative changes have set in this approach to treatment will be of limited value.

Summary

1. The management and prognosis of lesions of the conduction mechanism are discussed.
2. Congenital deafness is classified into endogenous (true genetic) and exogenous (environmental) types. Early special educational measures are important in congenital deafness.

3. Primary nerve deafness is not amenable to medical therapy but rehabilitation measures such as lip reading and auditory training are helpful and a hearing aid can be of benefit in many.
4. In secondary nerve deafness appropriate treatment or elimination of the etiology may be of value. Otherwise the problem is one of rehabilitation.
5. Hydrops of the inner ear, presumably the result of vasospasm, is a definitely recognizable clinical entity and under proper management over a period of time will frequently respond to treatment. Early institution of therapy is urgent.
6. The vasospastic concept of the etiology of Bell's palsy is briefly discussed.

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Recent Observations on Frostbite

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The term "frostbite" is often used to describe all lesions resulting from exposure to cold, regardless of any other contributing factors. Review of the syndromes associated with cold injuries indicates that they can be classified into two different groups. The first of these is true frostbite which is due to exposure to extreme cold. According to Brahdy¹ this condition is rarely seen above a temperature of 14°F. Damage occurs when the tissues actually freeze after first going through a stage of supercooling, and death of all involved tissue ensues. Ungley² describes cases of gangrene of digits which have resulted from this type of injury. He states that within a short time after injury, the skin just proximal to the line of demarcation usually recovers to such an extent that no sensory or vasomotor abnormalities can be demonstrated. These considerations lead to the conclusion that true frostbite results in local tissue necrosis of the involved area and minimal injury to the adjacent tissues. Distinguishable from frostbite is a generalized involvement of the tissues which has been aptly termed "peripheral vasoneuropathy after chilling" by Ungley². This includes a group of closely allied conditions which are almost identical, and which have been variously named: Trench foot; immersion foot; shelter foot; lifeboat leg; waterbite; and seaboot foot. This condition follows exposure to moderate cold, often above freezing, and is almost always associated with a wet environment. The dampness of an air-raid shelter or the perspiration from an individual's feet often is sufficient to provide the necessary moisture. Water or moisture is a good conductor of heat and allows chilling throughout an extremity for a prolonged period. Another important contributing factor is the ischemia produced by tight footgear and

clothing, cramped position, prolonged immobility, and pressure on the posterior thighs and popliteal space from sitting on hard surfaces. The resultant damage of the affected part is of a generalized nature and often is associated with irreversible changes in the muscles and nerves. For purposes of simplicity this condition will be referred to as trench foot.

The experience with frostbite in the Korean conflict has brought to light large gaps in our fundamental knowledge of cold injury. The Army's Cold Injury Research Team from our research laboratory at Fort Knox, Kentucky, has observed and we quote: "One of our major errors in the past seems to be that of producing and studying a type of experimental lesion that is not at all comparable to that experienced by our military personnel in Korea—in its etiology, pathology, or response to therapy. Experimental frostbite usually has been produced by one of three methods: (1) a quick-freeze technique of immersing an animal's foot or ear in alcohol cooled by dry ice; (2) surrounding the animal's part with ice packs and applying pressure, with or without a tourniquet; (3) exposing a narcotized animal to a low environmental temperature, with resultant hypothermia and cold injury. In no respect do these methods simulate the etiological factors in uncomplicated frostbite of the average American soldier in Korea. His lesion is typically a slowly-developing one, incurred after several days exposure to dry cold (usually 15 to 30 degrees below zero Fahrenheit), often immobilized in a fox-hole, and accompanied by physical exhaustion and frequently inadequate caloric intake. In severe cold injury of this type, the lesion itself is never sharply defined, but contains areas of 4th, 3rd, 2nd and 1st degree frostbite, usually arranged in this order from the distal to the proximal point of involvement. To produce a strictly similar experimental lesion, an animal should

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be exposed several days to a dry low environment temperature, with limited food intake but not narcotized and without tourniquet."

Frostbite may be classified according to degree in a manner similar to the classification of burns. Indeed, the injuries to the superficial tissues following frostbite resemble thermal burns to a great extent. After thawing, the extent of involvement is as follows:

First degree: Reddening of the skin without blister formation. This may be followed by superficial desquamation.

Second degree: Blistering of the skin with destruction of the entire epidermis and varying depths of the underlying derma. The blisters usually contain clear serous fluid.

Third degree: Destruction of full thickness of skin and varying amounts of subcutaneous tissue. Blisters may or may not be present. If blisters form, the fluid usually is bloody since blood vessels are destroyed. Superficial dry gangrene occurs and if there is infection the gangrene is wet.

Fourth degree: Necrosis of entire thickness of a digit or extremity. The initial gangrene usually is of dry type, but may be wet at the line of demarcation. The final stage is mummification of the involved part.

There is much controversy over the treatment of frostbite, particularly during the stage of thawing or warming. Some advocate extremely slow warming, even to the extent of placing the involved part in an environment a few degrees above freezing for several hours or a few days. Others believe that rapid warming should be accomplished with the environmental temperature the same as that of the body. An intermediate group allows the thawing or warming to take place at room temperature. Recently Finneran and Shumacker³ reported experiments which demonstrate remarkable efficacy of rapid thawing at 42° C. in the early treatment of experimental frostbite in the tails, feet, and ears of a number of animal species. Translated to human frostbite it would appear that rapid thawing of a frozen part at a temperature just above body temperature would prove of great value in preventing loss of tissue. There is general agreement that warming should not be at a high temperature such as would be

obtained from exposure to a fire or immersion of the part in hot water.

The use of sympathetic blocks, sympathectomy, and autonomic blocking agents has not been completely evaluated, but animal experimentation by Finneran and Shumacker³ indicate that their use may be of value in the early treatment of frostbite. Their evidence suggested that the production of vasodilatation has never proved harmful in experimental frostbite and, though variable results have been obtained, has tended to be beneficial. On the other hand, Greene⁴ does not recommend the use of sympathetic blocks since he believes that it adds to the deleterious edema and transudation which are present in the early stage of recovery.

Lange, Boyd and Weiner⁵ have contributed greatly to our present knowledge of the pathology and physiology of acute frostbite in experimental animals by use of the fluorescein test, the capillary microscope, and histologic studies. They demonstrated that gangrene after frostbite is due to a tremendous increase in capillary permeability, which leads to loss of plasma from the blood stream into the tissues so that the red cells silt up the capillaries due to loss of suspending fluid. This red cell sludge solidifies and is finally converted into hyalin thrombi. These masses of agglutinated red cells obstruct the blood stream locally and lead to the gangrene of the dependent tissue. These same authors⁵, in another animal experiment, conclude that prevention of gangrene which appears to be due to occlusive red cell thrombi after severe frostbite requires a continuous uninterrupted prolongation of the coagulation time, never shorter than 30 minutes, by heparin injections or infusion for at least 5 days after exposure. It is known that heparin sodium interferes with the adhesiveness of agglutinative thrombi and thus probably prevents the otherwise inevitable thrombosis and gangrene. Anticoagulants also preserve the resorbability of the interstitial fluid thereby preventing secondary fibrous tissue formation. Shumacker⁶ believes it is impossible to give absolute criteria for the effectiveness of anticoagulants in prevention or limitation of the extent of gangrene in frostbite. However, he believes that anticoagulant therapy is a valuable adjuvant in prevention of frostbite gangrene and, to be effective, the treatment should be started within 16 hours after exposure. More re-

cently Theis and associates⁷ reported their experience with 30 cases of frostbite seen at the Cook County Hospital in Chicago during the winters of 1949 and 1950. They treated 14 of these 30 cases with anticoagulants, because they were seen on the average of 10 hours following exposure. The remaining cases were of a longer duration following exposure and gangrene or necrosis of tissue was already present. They concluded that adequate anticoagulant therapy in the acute stage of frostbite is of great value in reduction of the incidence and extent of gangrene and the period of disability. The use of anticoagulants, such as heparin, was reported by Lange and Loewe⁸ in experimental frostbite on human volunteers. They believe it of great value in the early treatment.

Shumacker, White, and Wrenn⁹ studied the functional patency of arterial channels in dogs and rabbits during and after frostbite by means of arteriography. Arteriograms of dogs made within a few minutes of removal from the freezing mixture showed no opacification of vessels below a point a few centimeters proximal to the upper level of freezing. It was possible to obtain normal arteriograms 10 hours after freezing in which the coagulation time was kept constantly prolonged by large doses of heparin. Comparison of results of arteriographic studies after varying periods of exposure to different degree of cold suggested that, despite variations from one animal to another, the more severe the exposure the shorter the period after thawing during which the arterial tree opacifies in the injured area and vice versa. In cases of frostbite severe enough to cause gangrene in the untreated animal the arterial circulation is generally not full and complete during the period of restored blood flow that follows thawing, and when full circulation does occur it tends to be of relatively brief duration.

Fuhrman and Crimson¹⁰ studied the effectiveness of rutin on rabbits in preventing gangrene after standardized severe cold injury to feet and ears. They found that in none of the rutin treated animals was the tissue loss as great as that in the controls and concluded that rutin may act by altering the blood flow through the capillary bed.

During the period 25 November 1950 to 25 March 1951, there were 62 cases of frostbite admitted to Letterman Army

Hospital. The interval between onset of the frostbite and admission to Letterman Army Hospital varied from two to four weeks. The initial treatment in overseas hospitals of most of these patients was standardized as follows: Early warming or thawing at room temperature without dressings and with involved parts at or just below heart level; stimulating dose of tetanus toxoid; intra-muscular penicillin; intravenous infusion of 1 gram of procaine in 1000 cc fluid twice daily; and multivitamins including thiamin and nicotinic acid. The patients also were instructed to discontinue smoking.

A standard intravenous frostbite solution was later formulated in the Far East Command. This consisted of individual flasks containing 12 cc of ethyl alcohol, 250 mgms of procaine hydrochloride, and 5% glucose in water to make 250 cc. The contents of this flask were to be repeated every six hours through the chain of evacuation with the treatment started as early as possible after a diagnosis had been established. One hundred mgms. of heparin were supplied as a separate unit with each one of these flasks. It was added to this solution when there were no coexistent wounds which, in the opinion of the medical officer, would contraindicate its use.

After admission to Letterman Army Hospital the patients received treatment on an individualized basis. A few of the mild cases required no treatment and after a short convalescent leave were returned to duty. The cases with blistering of the skin or gangrene were initially placed at bed rest or allowed up in a wheel chair with the involved parts exposed to the air without any dressings whatsoever. This materially aided in the production and maintenance of a dry type gangrene. Protection from bed sheets was accomplished by the use of cradles. The affected areas were handled at all times with extreme gentleness in order to prevent trauma to the tissues and rupture of blisters. Sterile technique was followed whenever cleansing or debridement was performed. Penicillin, three to six hundred thousand units daily, was used in the treatment of infections and also in many potentially infected cases. Frank suppuration was not a serious problem. Crusts were allowed to separate spontaneously and were removed as indicated. Rehabilitation treatment of the affected parts then was continued on the Physical

Medicine Service. Priscoline in 50 mgm. doses four times daily was administered for its vasodilating effect to those patients with gangrene and to milder cases who complained of loss of sensation or mild pain in the involved part. We are of the opinion that this vasodilator contributed materially to the relief of distress over the affected parts.

Cortisone and ACTH have been used by Orr¹¹ and his associates in Japan in conjunction with the study of more than 4,000 cases of frostbite. Fifty-five cases of fourth degree frostbite were selected; twelve were treated with ACTH, twenty-two with cortisone, and twenty-one were used as controls. Four hundred mgms. of cortisone were administered orally the first day, three hundred mgms. the second day, and two hundred mgms. daily thereafter. Twenty mgms. of ACTH in 1000 cc's of 5% glucose were administered intravenously over a six hour period daily. These drugs were given over a period of thirty days. The evaluation of the therapeutic efficacy was achieved by clinical observation, by periodic photographs, and by x-rays. No clinically significant effect of the drugs was apparent during the course of therapy nor did they appear to prevent any residual disability over the short follow-up period available to date. Cortisone also has been used by Dickinson¹² at Oak Knoll Naval Hospital in 18 cases of severe 4° frostbite without significant benefit.

Severe pain was an unusual complication in our series of cases. The majority of patients stated that they had mild discomfort for the first few days, but that this usually disappeared within a week. The few cases which sustained 3rd and 4th degree frostbite stated that they had moderate to severe pain during the first week or ten days, but that at the time of admission to Letterman Army Hospital the pain had either disappeared or was extremely mild. One case of 4th degree frostbite of the toes complained of rather severe pain during the first few days of hospitalization, which was only partially relieved by priscoline. A lumbar sympathetic block gave immediate complete relief and the pain afterwards was not of sufficient severity to require additional blocks. It is interesting to note that this patient previously had suffered from a moderate bilateral trench foot which he incurred in Europe in 1944. It should be recalled here that the sequellae of trench foot are disturbances of sensation, sweat-

ing, atrophy, and muscle paralysis. A lowered threshold to cold is very prominent also.

The appearance of the involved part is deceiving since in the early period the depth of the gangrene cannot be estimated with any accuracy. Superficially the area of gangrene is always much more extensive than in the deeper tissues. After a few weeks an apparently gangrenous digit may slough a cast of the skin and fingernail to reveal intact underlying skin and soft tissues. We have found that a true line of demarcation of the gangrene does not become apparent until an average of about six weeks following the initial cold injury. This figure is variable, of course, and in some severe cases gangrene of the full thickness of the involved part is apparent much earlier. Three of our cases have stated that the initial appearance of their feet was so frightening that they were firmly convinced that they would lose at least the distal half of each foot. The most severe of these three cases finally required amputation of the first four toes of one foot and the first three toes on the other.

Amputations were performed when an obvious line of demarcation became evident, usually after about six to eight weeks. The feet of a patient with severe 4th degree frostbite are shown in Fig. 1. There is entire destruction of the extremity. An arteriogram, Fig. 2, shows that the blood vessels have been completely occluded distal to the line of demarcation. Conservative therapy is plainly hopeless. The histological sections, Figs. 3, 4, and 5, through the line of injury demonstrate relatively normal tissue above, inflammatory reaction at the line of demarcation, and complete necrosis below.

There were two bilateral amputations below the knee of the 62 cases admitted to Letterman. Five patients required amputation through the distal portions of the metacarpals or metatarsals. Seven cases had amputation of all or portions of one or more digits.

Two of our cases developed acute infections after being placed on the surgery schedule for amputation of toes. The infections rapidly subsided under appropriate treatment and the amputations were performed without difficulty a few days later. This experience is a reminder that conservatism, important as it is, should not be carried to such an extreme



Figure 1. (This and the subsequent illustrations were furnished by the Letterman General Hospital Photographic Laboratory, San Francisco, Cal.)



Figure 2.

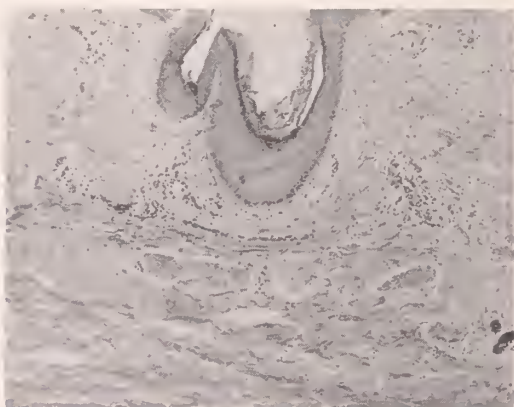


Figure 3.



Figure 4.

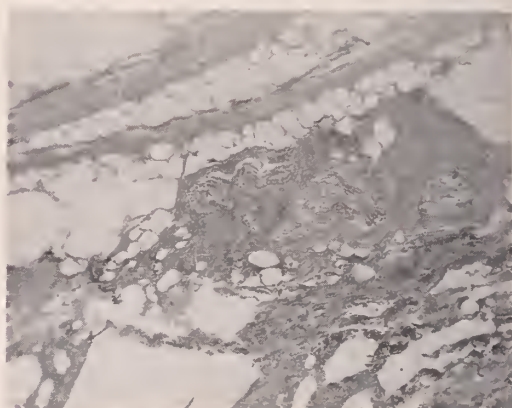


Figure 5.

that it becomes procrastination.

Summary

Frostbite results in local tissue necrosis of variable extent following exposure to a temperature below freezing. The initial appearance is deceptive since in many cases, after separation of the eschar, the underlying tissues are viable. Conservative treatment instituted as early as possible after incurrence should consist of:

- a. Rapid thawing at room temperature of 72-78° with complete exposure of involved parts
- b. Stimulating dose of tetanus toxoid
- c. Penicillin
- d. Administration of frostbite solution with heparin for a period of seven to ten days depending on the individual case
- e. Blisters to be left intact

- f. Multivitamins and nicotinic acid
- g. Administration of vasodilators in selected cases
- h. Contradiction of tobacco.

Amputations should be delayed for a period of four to six weeks except, of course, in the presence of spreading infection which would endanger life. An organized and adequate follow-up system should have authentic data in the future as regards the incidence of the so-called "cold foot syndrome," which resembles very closely the well known sequellae of trench foot.

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Special Article

Edgar Erskine Hume, Major General, MC, U. S. A.

(1889-1952)



Major General Edgar E. Hume, MC, U. S. A.

In the death of General Hume, Kentucky lost one of its most distinguished physicians. The Armed Services lost a most efficient and indefatigable medical officer, the most decorated one in the history of the United States. The Centennial Program Committee of the Kentucky State Medical Association had extended to General Hume an invitation to participate in the Centennial Meeting. He accepted tentatively but was unable to meet with us though a place was kept open to the end of the meeting. General Hume, though at home in any part of the world, always evinced a deep and abiding love for his home state and for Kentuckians wherever they were met.

Edgar Erskine Hume, son of Dr. E. E. and Mary (South) Hume, was born in Frankfort, Kentucky, 26 December, 1889. After attending the Frankfort schools he entered Central University (now Centre College), Danville, Ky., and was graduated, A. B., in 1908. In High School and especially at Centre College he gave evi-

dence of those qualities of leadership and scholarship which were to distinguish him throughout life. At Centre he was head of his fraternity, business manager of the football team, president of his class and an outstanding student. In 1909 he obtained his Master's degree from Centre. His thesis was entitled, "Old Germanic Customs and Characteristics and their Reflection in the Niebelungenlied." He next entered Johns Hopkins University School of Medicine and was granted an M. D. degree in 1913.

After a year's internship in the Johns Hopkins University Hospital, Dr. Hume went to Munich and on to Rome for post-graduate study. While at Rome there came his first opportunity to perform a noteworthy feat. A severe earthquake occurred in the province of Abruzzi and the U. S. Ambassador to Italy placed Dr. Hume in charge of the American relief train to carry medicine and supplies to the stricken area. For this work he received the first of his numerous decorations, the Order of St. Maurice and St. Lazarus, the highest award in the power of the King.

Returning home he entered the regular Army Medical Corps in 1916. He was an honor graduate of the Army Medical School in 1917. Hume's first assignment was that of executive officer of the Division of Sanitation in the office of the Surgeon General. With the temporary rank of Lt. Colonel he was placed in command of all United States Hospitals in Italy. Later he served with the British Expeditionary Forces and in the Meuse-Argonne and St. Mihiel offensives. After the war he was appointed chief medical officer and Director of the American Red Cross in Serbia. Here he fought successfully a serious outbreak of typhus fever for which he received his first Distinguished Service Medal.

Space does not permit mention of all his important assignments between the two world wars. Scholarly and studious, his most pleasant assignments no doubt were to the great Army Medical Library where

he was Editor of the superb *Index Catalogue* from 1922 to 1926 and Librarian from 1932 to 1936. These years constitute his most productive literary periods during which he wrote dozens of essays and several books. It has been stated that he wrote "some four hundred books and pamphlets on medical and other subjects."

World War II saw him in North Africa on the General Staff planning for the invasion of Italy. He accepted the surrender of Naples and won the respect of the Italians by his diplomacy when he said: "Allow the Italian flag to fly by the Stars and Stripes: we come as liberators not conquerers." As chief of the Allied Military Government of the Fifth Army in the Mediterranean theatre, he controlled typhus epidemics, succored the needy after a volcanic eruption, rounded up hordes of the criminally insane released by the fleeing Germans and had Rome properly policed within thirty minutes after the entrance of the Allies. Probably General Hume's most noteworthy achievement among many was his administration of the Mediterranean theatre. As a result he was given honorary degrees, frequently decorated and made an honorary citizen of forty large Italian and Austrian cities. He was an accomplished linguist, fluent in five languages.

In 1949, he was promoted to the rank of Major General and made Chief Surgeon of the Far Eastern Command. Shortly thereafter he received an additional assignment as Surgeon to the United Nations Command in Korea. Here he was twice wounded. The wonderful medical record of the Korean "incident" has made history with its death rate of 1.8 per cent for combat wounds compared to 8.1 in World War I and 4.5 per cent in World War II.

General Hume's military decorations included three Distinguished Service Medals, the Silver Star with two clusters, the Legion of Merit, the Soldier's Medal, Army Bronze Stars, a Navy Bronze Star

and the Purple Heart. He held degrees from many universities in the United States and in eight foreign countries in addition to decorations from 37 countries in Europe and Latin America. He held Fellowships in both the American College of Surgeons and the American College of Physicians. He was a Diplomat of both the American Board of Internal Medicine and of Psychiatry and Neurology. General Hume was a member of many societies both at home and abroad, one-time president (1947-48) of the Association of Military Surgeons of the United States and once Editor of *The Military Surgeon*. As President of the Society of Cincinnati he decorated Winston Churchill with the "Eagle" of the Society. Churchill then said: "This is the most eventful day of my not uneventful life."

General Hume was retired from the Army on 1 January 1952. On 24 January 1952, he entered Walter Reed Hospital, Washington, D. C., where he died suddenly on the following day of a dissecting aneurysm of the abdominal aorta. His immediate superior said of him: "The most brilliant medical officer of all time. Never shall we see his like again." Eulogies were delivered in the United States Senate. The Kentucky Legislature, then in session, adjourned upon the announcement of his death. Newspapers all over the world carried editorials praising him. *The Baltimore Sun* said: "... He was perhaps the most brilliant graduate of Johns Hopkins." *The Courier-Journal* (Louisville) repeated what had been said on the occasion of the award of the Distinguished Service Medal to him for the third time, that he was "by proven record one of the most valuable men in Army uniform—and, it might be added, in the world today if an influence in saving lives beyond calculation is the basis of judgment." It was fitting that General Hume should be buried in Arlington Cemetery among other illustrious dead.

EMMET F. HORINE
Brooks, Kentucky

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ELECTION BY DEFAULT

The 1952 elections may be decided by default by the responsible citizens refusing to exercise their right to vote. The election in 1948 turned on the "stay at home vote."

A recent poll taken by a group in Dallas County, Texas, showed that only one out of four voted in the seven professions sampled in the 1948 election. Comments the Dallas Morning News, "Yet it is the Doctor, the lawyer, the engineer, who bemoan the threat of socialism and burdensome debt. The doctor who fears socialized medicine and does nothing at the polls to combat it is legion. The Dallas poll merely proves locally a national picture which is pitiable."

The desire that elections will continue to be decided by the stay at home vote is one of the most important cards in the socialist's deck. He hopes to quietly operate, always in the name of "humanitarian" and gain his point by default. History lists the multitude of successes his plan has enjoyed.

The last day to register for the primary in Kentucky in 1952 is June 2, and for the November election it is September 4.

Be sure you are a qualified voter. See that you, members of your family and employees, are registered. If you can do this and do not make the effort, then shouldn't you be listed as a political slacker?

THE CENTENNIAL VOLUME

The Centennial Volume will be ready for distribution in the very near future. It is edited by Emmet Field Horine, M. D., a nationally recognized medical historian and official historian of the Kentucky State Medical Association. The Volume is officially entitled, "Papers Presented Before the Ephraim McDowell Memorial Meeting, Centennial of the Kentucky State Medical Association."

One of the many features of the Volume is the absorbing and beautifully written historical sketch of the life of our Association. Meticulous as to accuracy, Dr. Horine does not sacrifice interest and readability in giving this most engaging 13-page account. The sketch is well illustrated with material, some of it having been published over 100 years ago.

In addition to describing the struggle the young Association experienced in its early days and its growth down through the years, Dr. Horine mentions many of the discoveries that were made in medicine during the first 100 years of the Association that are so well known today. The interest of the Association in medical education and its development in Kentucky is outlined.

Near the close of the sketch, Dr. Horine points up the responsibility of medicine in providing adequate medical care for all. The Twelve Objectives of the Association, endorsed by the Council and adopted by the Centennial House of Delegates, are listed.

Dr. Horine closes his sketch with this

challenge. "The purpose of this sketch has been to note briefly the progress of the Kentucky State Medical Association in relationship to the medical advances of the past century. The situations which challenge us as we enter upon a new century are manifold. Let us emulate the faith and energy of our predecessors and resolve that we shall serve our fellowmen not less steadfastly than they."

Other features of the Volume include pictures of all the past presidents of the Association and all available photographs of its secretaries. There is a sketch of Ephraim McDowell, who was memorialized by the Centennial Meeting. The first Presidential Address is given and other interesting historical matter includes material covering memorials and meetings.

The scientific program presented at the Centennial Meeting was given by physicians who were Kentucky born or educated, who had distinguished themselves beyond our borders. The Volume carries these papers, pictures of the essayists and a brief biographical sketch of each.

Due to the great amount of varied material assembled in this 200-odd page volume, many months of hard work, discouraging experiences and difficult problems were encountered by the Editor. The Association made an appropriation to cover this splendid service; however he has refused any compensation. We believe the Association owes Dr. Horine a lasting debt of gratitude.

AN UNDERWRITING APPROACH TO THE "MEDICAL DISASTER" PROBLEM

A new kind of insurance which is of vital importance to the medical profession has recently been made available to the public. It is designed to cover very large medical expenses, and provides for the first time really adequate protection against the kind of bills which accompany serious illness or a bad accident.

The various hospitalization and medical insurance plans to which we are accustomed all contain limits on the amount of benefit which is available in any particular case, with these limits set in relation to the costs of the "average" ill-

ness. Generally the policies cover up to a few hundred dollars of expense, and they provide a broad base of protection. There is, however, an even greater need for insurance against the relatively rarer but more disastrous cases which result in much larger expenses, and it is to fill this need that the new coverage has been developed.

One policy which is being sold on an individual or family basis provides benefits up to \$5000 for each illness or accident, covering all types of expense which are incurred during hospital confinement

—doctor's fees, both for surgical and for medical attention, nursing costs when a private duty nurse is required, and all charges made by the hospital itself. Instead of applying specific limits to specific items of coverage—there is no "schedule" of maximum reimbursement for the various surgical procedures, for example—the policy covers three-quarters of the bills whatever they may be. This approach keeps the coverage flexible and uniformly effective for all types of service; at the same time, the insured's direct interest in his bills to the extent of 25% is expected to control any tendency toward unnecessary or unreasonable expenses incurred just because the insurance exists.

Small items of medical expense are deliberately excluded from the scope of the policy by means of a "deductible," the coverage commencing at a level such as \$100, \$300, or \$500 according to the needs of the insured. This, too, is an innovation in medical insurance, although the concept is familiar in automobile collision insurance. Aside from its obvious effect in keeping the premium down, the deductible idea emphasizes the distinction between the proper area for budgeting and the proper area for insuring; it also plays a most important role in making it possible for the insured to supplement existing coverage with protection which begins where his present plan reaches its limit.

The American public is more than ever conscious today of the need for protection against the financial impact of serious illness. Many people have realized that it is the expense of several hundred or several thousand dollars, rather than the expense of a hundred dollars or two hundred, that constitutes the real risk for which medical insurance is needed. The development of the "medical disaster" policy comes as an indication that this need is recognized and can be filled, as other insurance needs are, by private en-

terprise through voluntary means and without government compulsion. We as doctors can understand the tremendous significance of this latest step, and while the large benefit amounts provided without specific limits place a responsibility on all those who furnish medical service and its concomitants to see that no abuses arise which could work against its success, we can also feel proud of the opportunity to speak of its accomplishment to our patients.

Physicians are urged to take a more active interest in the Reed-Keogh bill, a voluntary pension plan now pending in Congress, as stated in an editorial appearing in the April issue of the American Medical Journal. This bill, with an amendment to the Federal Internal Revenue Code, would enable self-employed professional persons and some employed persons to exclude from current taxable income amounts sufficient to finance a reasonable retirement annuity. The annuity would have to be declared as taxable income as it is received during their retired years. The American Medical Association, the American Bar Association, the American Dental Association and other groups have banded together to support this plan, rather than have the Social Security Act cover them.

In reply to a letter from Paul B. Magnuson, M. D., Chairman of the President's Commission on the Health Needs of the Nation, requesting that the A.M.A. make available pertinent information in its possession to assist the commission, the Board of Trustees of the A.M.A. told the commission it is welcome to go over any of the medical data which the A.M.A. has in its possession and which might prove helpful. However, the Board said it did not want this to be construed in any way as approval of the commission's activities, which it believes to be of political intent.

ORGANIZATION SECTION

Eleven Guest Speakers To Feature 1952 Scientific Session

Plans for an unusually strong scientific program at the 1952 Annual Meeting in Louisville, October 7, 8, and 9, are well advanced, Clark Bailey, M. D., Harlan, K.S.M.A. President and Chairman of the Committee, told the Executive Committee at its April 3 meeting.

Eleven guest speakers, bringing to Louisville men of national reputation in their respective fields, will be on the program, Dr. Bailey said. In addition, eleven outstanding Kentucky physicians will be invited to participate. There will be the traditional oration in medicine and surgery given by Kentuckians elected to this honor the year before.

[Civilian Defense, in its various aspects, will receive special emphasis, Dr. Bailey said. Explaining that the Governor, Lawrence W. Wetherby, manifested special interest in this problem, it was stated a nationally known authority will address the public meeting on Tuesday evening, October 7. Wednesday, October 8, a symposium on treatment of atomic illness will be presented. There will also be a special scientific exhibit.

Dr. Bailey said his committee had been working very hard on this meeting and hoped to announce the tentative program in an early issue of the Journal.

U. of L.-K.S.M.A. Seminar To Be Held June 2 and 3, 1952

The Medical Seminar of the University of Louisville School of Medicine and the K.S.M.A. will be held June 2-3, 1952, at the Kentucky Hotel in Louisville, Herbert L. Clay, M. D., Director of the Postgraduate Refresher Training Department of the School, has announced.

This refresher program is open to all physicians in Kentucky and surrounding states. Eight credit hours will be given members of the Academy of General Practice attending the Seminar.

The plan for the scientific program of the second day has been changed this year. Instead of having varied subjects, the plan is to cover a specific system or organ. The subject chosen for this time is the Biliary Tract.

The sponsoring organizations, according to Dr. Clay, are: Jefferson County Medical Socie-

ty; Kentucky Academy of General Practice; Kentucky Committee of Fractures and Other Trauma of the American College of Surgeons; Kentucky Division of the American Cancer Society; Louisville Regional Blood Center of the American Red Cross; and the Kentucky Heart Association.

On Monday, June 2, Registration will be from 9:00-10:00 A. M. The following are some of the speakers and their subjects on the morning and afternoon program: Charles Puestow, M. D., "Carcinoma of the Oesophagus"; Gray Twombly, M. D., "Carcinoma of the Cervix"; Carl V. Moore, M. D., "Hematology"; Amos Christie, M. D., "Histoplasmosis"; Grover C. Penberthy, M. D., "Abdominal Trauma."

Tuesday, June 3, the program is as follows:
9:00- 9:30 Samuel A Overstreet, M. D.,—Hepatitis

9:30-10:00 J. Richard Gott, M. D.,—Cirrhosis

10:00-10:30 John Neefe, M. D.,—Diagnostic Aids in Liver Disease (Hepatic Tests and Needle Biopsy)

10:30-10:45 Intermission

10:45-11:15 Foster D. Coleman, M. D.,—Cholelithiasis and Cholecystitis

11:15-11:45 Arthur M. Schoen, M. D.,—Pancreatitis

11:45-12:15 Joseph E. Hamilton, M. D.,—Oesophageal Varicosities

2:00- 3:00 The Institute for Medical Research of the University of Louisville School of Medicine is located on the second floor of the Louisville General Hospital at 323 East Chestnut Street. There will be demonstrated various types of clinical, investigational procedures that are now being carried out in the Institute. All are urged to visit the Institute and see it in operation.

National Officers Attend KSMA Diabetic Committee Session

John A. Reed, M. D., Washington, D. C., Secretary, and J. Richard Connelly, New York, Executive Director of the American Diabetic Association, were the special guests of the Committee on Diabetes of the Kentucky State Medical Association at a luncheon meeting held April 10 at the Brown Hotel in Louisville, Carlisle Morse, M. D., Louisville, Chairman of the Committee, said.

In addition to the special out of state guests, Clark Bailey, M. D., Harlan, President of the Association, and Richard R. Slucher, M. D., Buechel, President of the Kentucky Academy of General Practice, were on hand to welcome the visitors at the session which was attended by twelve.

Dr. Reed told the Committee that his organization was very much impressed with the work Kentucky had done in its initial effort last fall as the Committee conducted the first diabetic detection drive in Kentucky. He emphasized that the American Diabetes Association was the only voluntary health organization that was sponsored, operated, and controlled by physicians, and that it was not a fund raising organization.

Mr. Connelly emphasized the value of the educational and statistical work done by the Diabetic Association and explained how it operated. He said there were over 800 county and state medical societies that participated in the 1951 detection job. In a discussion period, he and Dr. Reed provided the Committee with many helpful suggestions and distributed material for its use.

Dr. Bailey pledged the cooperation of the K.S.M.A. in the drive this fall and Dr. Slucher said the Academy would give the effort its support. Dr. Bailey said a special spot had been reserved on the program at the Annual Meeting for an outstanding speaker on Diabetes and Dr. Morse reported that the October issue of the Journal of the K.S.M.A. would give special emphasis to Diabetes.

According to Dr. Morse, the special guests made a splendid contribution to the meeting and he and his Committee were most grateful for their willingness to attend. He said that Dr. Reed had arranged for Thomas Sharkey, M. D., Dayton, Ohio, to be present, but that due to illness, Dr. Sharkey, who attracted national interest in his diabetic work in industrial firms, could not attend.

All Technical Exhibit Space For 1952 Meeting Sold

All space allotted to the technical exhibits at the Annual Meeting at the Columbia Auditorium October 7, 8, and 9, was absorbed by the exhibitors three days after it was offered, Carlisle Petty, M. D., Louisville, Chairman of the Technical Committee, announced.

Sixty booths will carry a well balanced group of companies dealing with drugs, instruments, equipment, literature, and other essential services and will comprise one of the special attractions of the 1952 session, Dr. Petty said.

Pointing to the progress that has been made in developing the realization that the technical exhibit is an integral part of the meeting, Dr. Petty urged the membership to visit each booth in the exhibit hall this fall and manifest a friendly interest.

"The fact that our exhibitors engaged all of our space in three days, when normally it has taken three months to rent the booths, focuses attention on the fact that cooperation on the part of our membership is most desirable," Dr. Petty stated, "as our technical exhibit hall is improved our meeting will show a corresponding amount of progress."

Dr. Horine To Address Cincinnati Academy On Daniel Drake

In addition to being memorialized by the 1952 annual meeting of the Kentucky State Medical Association, October 7, 8, and 9, the colorful pioneer Kentucky Physician, Daniel Drake, will be honored at a number of places in the nation, on the 100th anniversary of his death.

Emmet Field Horine, M. D., Brooks, K.S.M.A. Historian, will deliver the address of the evening at a special meeting of the Cincinnati Academy of Medicine, honoring Dr. Drake, at the University of Cincinnati, the evening of May 27.

The title of Dr. Horine's address is "Cincinnati Unique: Daniel Drake," and the paper will appear in the Academy's publication, the Journal of Medicine, simultaneous with the meeting. Prior to the evening meeting, the Academy will have special exercises at Dr. Drake's grave, when a new bronze marker is to be placed on the stone.

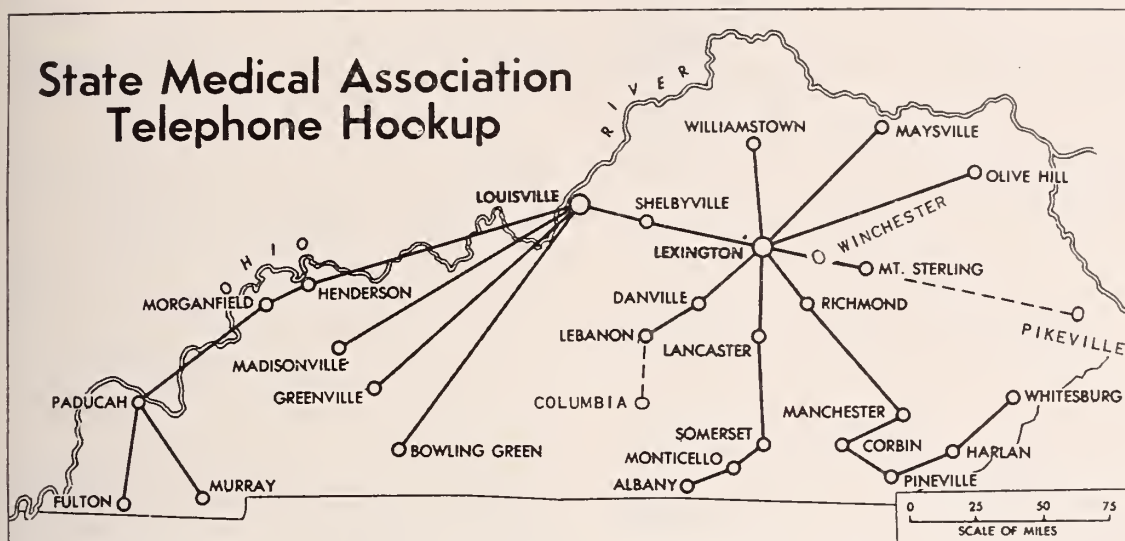
A special Daniel Drake exhibit will be on display at the meeting of the College of Physicians at Philadelphia, this spring.

Dr. Horine spoke to the American Association of the History of Medicine at Kansas City, Kansas, on May 1. His subject was, "Daniel Drake and the Beginning of Medical Journalism in the Missouri Valley."

Pediatrics P. G. Program June 5

The yearly Postgraduate Course in Pediatrics under the auspices of the Kentucky State Medical Association and the University of Louisville School of Medicine will be given at Children's Hospital, Louisville, Kentucky, beginning Thursday, June 5, at 9:00 A. M. to 12:00 noon. The sessions will be eight in number on consecutive Thursdays. A nominal fee of \$10.00 will be charged to cover expenses.

State Medical Association Telephone Hookup



The above map shows the location of the original 25 listening points of the first Telephone Seminar, February 26, sponsored by the Kentucky State Medical Association in cooperation with the University of Louisville School of Medicine. Three additional outlets were added for the succeeding seminars (the last being presented April 22) as indicated by the dotted line—Pikeville, Columbia and Winchester. The map is used through the courtesy of Bob Clark and the Louisville Courier Journal.

Peter Overstreet To Lead Local Student AMA Society

Peter A. Overstreet, Louisville, a Junior at the University of Louisville School of Medicine, became the second president of the local Student A.M.A. at an election held early in April.

The new president is the son of Sam A. Overstreet, M. D., Louisville, who was president of the Kentucky State Medical Association during its Centennial year. Retiring president of the local Society is Charles McGaff, who is a member of the A.M.A. Executive Council.

Robert Brashear, a member of the Sophomore class, from Irvine, was elected Vice-President and for Secretary and Treasurer, the Society installed Genrose Haselwood, a Junior, from Louisville.

Four District Meetings To Be Held in May

Four Councilor District meetings have been scheduled for the immediate future according to information at the Headquarters Office as the deadline for the May issue of the Journal was met (April 10).

First District At Hickman

Two Memphis physicians have been asked to present the scientific program of the First District, Tuesday, May 6, at Hickman, Councilor

J. Vernon Pace, M. D., Paducah, announced.

The Fulton County Medical Society, of which John G. Samuels, Jr., M. D., Hickman, is president and J. A. Poe, M. D., Fulton, Secretary, will be the host group.

Thirteenth District At Ashland

The new Thirteenth District will hold its first meeting Tuesday, May 13, at the Henry Clay Hotel in Ashland, Clyde Sparks, M. D., Councilor, reported. Last year it met jointly with the Fourteenth District.

Wives of the members are invited to attend. Speakers to be heard are: Clark Bailey, M. D., Harlan, Marion Beard, M. D., Louisville, and Richard Elliott, M. D., Lexington. Boyd County will be the host society.

Second District At Owensboro

George T. Harrell, M. D., Winston-Salem, North Carolina, Professor of Medicine, Bowman & Gray, School of Medicine, will be the guest speaker at the dinner meeting of this district May 27, Walter L. O'Nan, M. D., Councilor of the district, announced.

The President of the Second District is F. Hays Threlkel, M. D., Owensboro, and the Secretary is O. T. Davis, M. D., Owensboro. The meeting will be held at the Owensboro Country Club.

First District At Paducah

Clark Bailey, M. D., Harlan, K.S.M.A. President and Bruce Underwood, M. D., Louisville, Secretary and General Manager of the Associa-

tion, will be the featured speakers at a meeting of the First District in Paducah, May 28.

J. Vernon Pace, M. D., Paducah, Councilor, who made the announcement, said the McCracken County Society would be the host group. Eugene Blake, M. D., Paducah, is President and George H. Widener, M. D., Paducah, is Secretary of the McCracken Society.

Nurses Scholarship Set Up By Muhlenberg Medical Society

The Muhlenberg County Medical Society has established a scholarship fund for at least nine Muhlenberg County girls to take the three-year Nurse's training course. The plan will become effective at the start of the September 1952 college year, according to the Central City Messenger.

The fund will lend the money to pay all the expenses of the students during the three years necessary to become a graduate nurse. One of the requirements of those receiving benefits is that the girls agree to work at the Muhlenberg Community Hospital one year for each year they receive scholarship assistance. No interest will be charged and only the principal borrowed must be repaid.

Dr. Miner Heads S. E. Urological

William R. Miner, M. D., Covington, was installed as president of the Southeastern Urological Society at its annual meeting held early in April at the Boca Raton Club, Boca Raton, Florida.

Over 550 physicians and their wives, from the eleven states that make up the society, attended the meeting. The 1953 session, over which Dr. Miner will preside, will be held at Havana, Cuba.

Dr. Coomer Installed As President Of State Dental Group

O. B. Coomer, D.D.S., Louisville, was installed as President of the Kentucky State Dental Association, and Ollie M. Lyon, D.D.S., Morehead, was elected President-Elect at a recent meeting of the association.

Some of the most prominent men in American dentistry attended the meeting held in honor of Robert P. Thomas, D.D.S., Louisville, whom they credited with doing more than any other person to raise and make uniform the standards of dentistry in the United States.

Dr. Thomas is a former president of the Kentucky State Board of Dental Examiners.

During his time in office he was largely responsible for running dental "diploma mills" out of business and for removing any taint of politics from examining boards.

Nichols V. A. Hospital Moves To New Nine-Story Home

The Veterans Administration has moved its hospital facilities, in Louisville, into its new nine-story, \$8,000,000 building thus ending six years' use by the V. A. of Nichols Hospital.

Carl W. Black, assistant manager of the hospital, said the new hospital with a capacity of 494 beds, has every facility the architects could devise for modern treatment of patients.

The old hospital, a one-story sprawling structure, before being taken over by the V. A. was an Army General Hospital. It was completed for Army use in the fall of 1942. The building covers 124 acres and has 148 buildings connected by 6½ miles of heated corridors.

Editorial Group Authorizes Changes in Officer Directory

Editorial Advisory Committee has authorized a change in handling the directory carried near the front of the Journal, at a recent meeting in the Headquarters Office.

The directory of officers and councilors of the Association will be moved to the beginning of the editorial section and carried beneath the masthead and the Board of Consultants on Scientific Articles.

The list of K.S.M.A. committee chairmen and county medical society presidents and secretaries of the state will be carried once each year in the organization section but they will not be carried each month as has been the custom.

The members of the Editorial Advisory Committee are: Guy Aud, M. D., Louisville, Chairman, James Hix, M. D., Owensboro and Richard Rust, M. D., Newport.

Student AMA To Hear Dr. Jillson

Dr. W. R. Jillson, Frankfort, practicing consultant geologist, will address the University of Louisville chapter of the Student A.M.A. on May 12 in the Amphitheatre of the Louisville General Hospital.

Dr. Jillson, an authority on Kentucky history, will speak on the early developments in the medical profession in Kentucky, Peter A. Overstreet, President of the local society, said in making the announcement of the meeting.

Sixth District Hears Seminar

An innovation in Councilor District meeting programs was scheduled for the Sixth District session, April 22, when Councilor L. O. Toomey, M. D., Bowling Green, arranged to have the last of the three telephone seminars as the scientific material for the evening.

The Warren County Medical Society was host to the 6th District at a dinner meeting in the Helm Hotel, Bowling Green. William C. Wells, M. D., Glasgow, is President of the district and Will Carson, M. D., is Secretary.

The subject of the telephone seminar was "Thyrotoxicosis."

Medical Directors Wanted By C. D.

The Federal Civil Defense Administration's regional offices are authorized to employ full time medical directors to handle medical civil defense problems arising within such regional geographical areas, according to the Council on National Emergency Medical Service of the American Medical Association.

In view of the difficulty the FCDA has encountered in locating physicians qualified and willing to accept these positions and the need for these medical directors, the Council is assisting in locating qualified individuals. The job pays \$10,800 per year.

If you are interested and other information is desired, write to C. Joseph Stetler, Secretary, Council on National Emergency Medical Service, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

Muldraugh Society Meets At Elizabethtown

The Muldraugh Hill Medical Society met Thursday, April 10, 1952, at the Brown-Pusey House, Elizabethtown. The following program was arranged:

MORNING SESSION

Case reports—"Diagnosis and Treatment of

the Toxic Thyroid," Malcolm Thompson, M. D., Louisville; "Migraine—Up To Date," Misch Casper, M. D., Louisville; "Schizophrenia," Thomas J. Crice, M. D., Louisville.

AFTERNOON SESSION

"Atypical Pneumonia," Lt. Leroy Homer, MC., Fort Knox; "Types of Fractures Requiring Open Reductions," Frank Strickler, M. D., Louisville; "Treatment of Myocardial Infarction," Lt. Herbert Kramer, MC., Fort Knox.

Charles F. Long, M. D., Elizabethtown, is president of the society, and Joseph C. Ray, M. D., Louisville, is secretary.

KSMA Lists New Members

Following is a list of new members which the K.S.M.A. welcomes into the Association:

Boyle—William R. Gabbert, Danville.

Caldwell—John E. Cotthoff, Princeton.

Fayette—Thomas R. Bryant, Jr., Lexington.

Floyd—R. E. Elliott, Lackey.

Franklin—F. E. Tierney, Frankfort.

Fulton—R. Luby Jones, Fulton.

Harlan—John C. Gaw, Alva; Milton D. Levine, Lynch; Charlotte C. Levine, Lynch; Russell L. Moseley, Lynch; Nathan A. Mascor, Lynch; Gerald Besson, Lynch; George R. McElroy, Closplint; Harry J. Solomon, Kenvir.

Jefferson—B. E. Canfield, (Resident) Louisville; A. Lemuel Rosenblatt, (Resident) Louisville; Letitia S. Kimsey, Louisville; Oren A. Beatty, Louisville; William E. Pugh, Louisville; E. Alden Terry, Jr., Louisville; Henry J. Beilman, Louisville; Ralph M. Denham, Louisville; Charles M. Brand, Louisville; Oscar J. Hayes, Louisville.

McCracken—H. S. Gardner, Paducah; O. D. Maxey, Paducah.

Madison—Norman Wheeler, Berea.

Perry—Irwin S. Miller, Hazard; D. L. Upchurch, Hazard; Kermit E. Jones, Tilford.

Pike—Marvin R. Batchelor, Virgie; Charles F. Wilson, Pikeville; Russell H. Davis, Pikeville.

Pertinent Paragraphs

The Southern Pediatric Seminar will hold its thirty-first annual session July 14 through July 26, 1952, at Saluda, North Carolina. An additional week, starting July 28, is to be devoted to obstetrical and gynecological problems. Members of the Academy of General Practice will receive full credit. For information, write D. L. Smith, M. D., Registrar, 187 Oakland Avenue, Spartanburg, South Carolina.

The University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania, will present a Postgraduate Symposium on Basic Sciences Related to Anesthesiology, June 2-6, 1952. The course will be limited to 50 participants. Registration and full particulars should be obtained from: Chairman of the Committee on Graduate Medical Education, University of Pittsburgh School of Medicine, 3941 O'Hara Street, Pittsburgh 13, Pennsylvania.

The State Medical Society of Iowa is building a new office. Construction began on the Society's new home about the middle of March. The building is to be 40 x 50 with full basement providing ample office space and facilities for committee meetings.

Before next fall, nursing expects to have a new national organizational structure. Instead of the six national organizations that are now concerned with professional nursing, there probably will be only two, the American Nurses' Association and the National League for Nursing. The ANA will promote the professional, general, and economic welfare of professional nurses and the NLN will be a "community centered" organization, according to the Joint Board of Directors of the Six National Nursing Organizations.

A new A.M.A. Committee has been formed to deal with problems in the fields of psychiatry and neurology. Leo Bartmeier, M. D., Detroit, is Chairman of the Committee, to be known as the Committee on Mental Health, and Lauren H. Smith, M. D., Philadelphia, is Vice Chairman.

The Veterans Administration has announced that more money was loaned to veterans for G. I. home loans last year than during any year since the program went into effect in 1944. Eligible veterans and unremarried widows of deceased veterans have until July 25, 1957 to apply for G. I. home loans.

The General Practice Group of the University of Tennessee has established a postgraduate training program for general practitioners that has been approved by the American Academy of General Practice. The program is designed to meet the practitioner's individual needs and is offered with from one to four weeks of training without charge. Those desiring further information may write to the General Practice Office, University of Tennessee, Memphis, Tennessee.

Joe Stanley Butterworth, Murray, is the only Kentuckian of a total of 108 senior medical students who have been accepted for intern training at U. S. Naval Hospitals beginning July 1, 1952, under the Navy's Graduate Medical Training Program, Rear Admiral Lamont Pugh, Surgeon General of the Navy has announced. He will be assigned to the Naval Hospital at Jacksonville, Florida.

The two top medical advisory groups to the Veterans Administration, the Special Medical Advisory Group and the Board of Chief Consultants, consisting of 43 of the nation's outstanding medical, dental, nursing, and dietetic authorities, have voted "full confidence" in the V. A. medical program under the direction of Admiral Joel T. Boone, Chief Medical Director. R. Arnold Griswold, M. D., professor and head of the Department of Surgery, University of Louisville Medical School, is a member of the Board of Chief Consultants to the V. A.

The Bureau of the Budget has informed Chairman Lehman of Senate Health Subcommittee that it cannot recommend passage of Emergency Maternity and Infant Care bills now under study and that it disapproves the plan for free hospitalization of servicemen's dependents, according to the Washington office of the A.M.A.

A decided increase has been made on the amount of material allowed for hospital construction by National Production Authority. All Hospital construction approved for the third quarter of 1952 is expected to start on schedule, according to FSA's Office of Civilian Health Requirements. In some cases substitutes will have to be used for copper brass mill and other scarce materials but the Agency expects no "carry overs."

Leonard A. Scheele, M. D., has been appointed Surgeon General of the U. S. Public Health Service for another four-year term, on unanimous recommendation of the Senate Labor and Public Welfare Committee.

President's Page

The Committee on Emergency Medical Service of the Kentucky State Medical Association.

Kentucky's Governor Lawrence W. Wetherby requested of our Association that we assume the lead in organizing the medical forces of the State so that we might cooperate fully in the program of Civil Defense for the State of Kentucky. Since the medical phase of civilian defense should be the responsibility of the medical profession, we accepted the challenge of the Governor and our Committee is in the early constructive stage of its work.

Guthrie Y. Graves, M. D., Bowling Green, Kentucky, is Chairman of our Committee on Emergency Medical Service. Dr. Graves recently spent several days in the States of New York and Virginia studying their plans of Catastrophic Medical Care. Paul W. Crawford, M. D., Deputy Director of Health Services of the State Civilian Defense Organization, is the coordinator between our Association and the State Government.

Recently your Committee on Emergency

Medical Service met with General J. S. Lindsay, Director of the State Office of Civil Defense, Dr. Crawford, F. C. Beelman, M. D., Federal Civil Defense Administration, Washington, D. C., and Thomas J. Farren, Regional Director Federal Civil Defense Administration, Cleveland, Ohio. At this meeting the probability of a bomb being dropped upon the City of Louisville with a casualty list of 75,000 to 100,000 people was emphasized.

Certainly we members of the medical profession would be derelict in our duty were we not prepared to handle such a casualty in this or any other catastrophe which may occur. All county societies have been asked to form a Committee on Emergency Medical Service to cooperate with the State Committee. Dr. Graves will soon want to know which doctors are to be assigned to the stricken area and which of those are to remain at home. Let us unite in perfecting a medical organization under competent leadership, which will render capable medical care for any major catastrophe which may happen in Kentucky.

Clark Bailey

County Society Reports

CAMPBELL-KENTON

The regular meeting of the Campbell-Kenton County Medical Society was held at St. Elizabeth Hospital on March 6, 1952. The meeting was called to order by the President, Dr. Walker Air. Dr. Air introduced the guest speaker, Dr. Marc J. Reardon, who spoke on "Unusual Pulmonary Problems."

BUSINESS:

The minutes of the previous meeting were read by Dr. Adair, and approved.

COMMITTEE REPORTS:

Physician's Exchange Committee: Dr. Schultz, chairman, stated that there was no report.

A list of physicians and their specialties was to be given to the Academy of Medicine. Permission was asked of the members to have placards printed for their offices, stating the same as in the yellow section of the phone directory regarding the telephone service. Also to have text printed instructing patients on emergency calls, to enclose in monthly statements. This text was read by Dr. Adair. They would be sold to members who desired them.

There was a discussion of the Telephone Service by Drs. R. Biltz, Caldwell, Baron, and Jos. Molony, who suggested setting-up the emergency service and announcing it in the phone book before the placards were made. Dr. Riley and Dr. Houston discussed this, and on motion of Dr. Schultz and seconded by Dr. Rust, the physicians in Erlanger were authorized to have the texts printed to enclose in their statements.

Publications Committee: Dr. R. C. Smith announced there would be a write-up in the next issue of the Cincinnati Journal of Medicine.

Maternal Health Committee: A letter from Dr. Joseph Molony was read by Dr. Adair regarding a maternity case that was unable to get a doctor. This was discussed and decided it was a problem for "Emergency Medical Service."

Treasurer's Report: Dr. Reik reminded the members that if their dues were not paid by April 1st, they would no longer be members of the Society.

Dr. Howard Molony gave an interesting report on "Malpractice Insurance." The following were suggested:

1. To have a representative to speak to the Society.
2. To have a sample policy for the members to read and discuss.

Discussions included Drs. Baron, Walsh, R. C. Smith, Jos. Molony and R. Hoffman.

On motion of Dr. Molony and seconded by Dr. Huesing, a representative was to visit and speak to the Society. A special meeting was to be called, which later was announced as March 26th.

UNFINISHED BUSINESS:

Application of Dr. Anthony Giglia was voted by ballot. Results—unanimously elected to membership.

NEW BUSINESS:

Application for membership of Dr. Bessie Lee Allnutt was read.

Meeting adjourned at 11:00 p. m.

Norman Adair, M. D., Secretary

JEFFERSON

The February meeting of the Jefferson County Medical Society was held on Monday evening, February 18, 1952, at the Seelbach Hotel. Seventy members were present for dinner and about 15 additional for the scientific program.

The meeting was called to order at 8:10 p. m. by the Vice-President, Dr. Thomas VanZandt Gudex, who presided in the absence of the President.

Dr. James Robert Hendon introduced the guest speaker, Dr. Willard O. Thompson, Clinical Professor of Medicine, University of Illinois College of Medicine, Chicago, Ill., whose subject was: "Uses and Misuses of Sex Hormones."

The business meeting began at 9:25 p. m. with the reading of the minutes of the previous meeting, which were approved.

The following new members were elected: Henry J. Beilman, M. D., Charles Max Brand, M. D., O. J. Hayes, M. D., and William E. Pugh, M. D.

The application for Emeritus membership from Dr. James S. Lutz, was approved.

Dr. Arthur T. Hurst, Chairman of the Program Committee, asked members to send the committee any suggestions they might have for future programs.

Dr. Sam A. Overstreet reported on the present status of Senate Bill 50, and urged members to contact representatives and work for the passage of this bill.

Meeting adjourned at 9:40 p. m.

Robert C. Long, M. D., Secretary

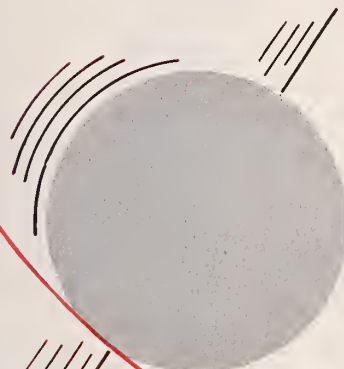


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Also of value as:

1. Kissin, M.; Stein, J. J., and Adelman, R. J.: *Angiology* 2:217 (June) 1951.

2. Rickles, J. A. J. *Florida M.A.* 38:263 (Oct.) 1951.

*Contains at least 80% of anhydrous theophylline.



SEARLE

RESEARCH IN THE SERVICE OF MEDICINE

McCRACKEN

The regular monthly meeting of the McCracken County Medical Society was held Wednesday, March 26, 1952. The meeting was called to order at 6:30 p.m. with Dr. Blake presiding. There were 21 members present.

After dinner, the scientific program was given. The guest speakers were James O'Leary, who spoke on "Encephelography" and Cecil Charles, who spoke on "Familial Headaches." Both men are from Washington University, St. Louis, Missouri.

Dr. Orr was appointed as publicity director to work with Bill Powell of the Paducah Sun-Democrat.

Dr. Robertson made a motion that the problem of 2 x 2 projector be investigated and one purchased. Dr. E. Pace, Dr. Blanton, and Dr. Widener were appointed as the committee.

Dr. Dunn announced that the third telephone seminar on "Management of Thyrotoxicosis" would be held April 22, 1952, at 7:30 p. m. at the Health Clinic.

Geo. H. Widener, M. D., Secretary

SCOTT

The Scott County Medical Society met for its regular monthly meeting on Thursday, April 3, 1952 at the John Graves Memorial Hospital in Georgetown. The following members were present: Drs. E. C. Barlow, F. W. Wilt, L. F. Heath, P. H. Crutchfield, W. S. Allphin, A. F. Smith, H. G. Wells, and H. V. Johnson. Messrs. Joe and Will Kelly were also present.

Mr. Will Kelly spoke to the Society and gave a demonstration of some of the intravenous outfits that he sells for the Cutter Laboratories of Berkley, California. The motion was made and seconded that we ask Mr. Kelly to put some of his solution in for trial and take back any that is not satisfactory. Carried.

Mr. Joe Kelly, Superintendent of the hospital, reported that they hope to have plans and contract signed for addition to the hospital

by June 30, 1952.

There being no further business, the meeting was adjourned.

H. V. Johnson, M. D., Secretary

UNION

The regular meeting of the Union County Medico-Dental Society was held at Our Lady of Mercy Hospital, at 7 p. m., March 18, 1952, following the dinner and staff meeting of the hospital.

Members present were: Drs. Carr, Conway, Allen, Humphrey, Welker, Martin, Cottingham and Smith.

The meeting was called to order by William Humphrey, M. D., President. Minutes of the last meeting were read and approved.

The names of various appointed committees were read.

As this was the second Telephone Seminar broadcast, no business was taken up. The broadcast came in very clearly. By the comments made, this program was enjoyed by all. It was timely and very instructive, and we now look forward to the April broadcast on "Thyrotoxicosis and Its Management."

There being no further business the meeting was adjourned.

A. W. Andreasen, M. D., Secretary

WARREN-EDMONSON-BUTLER

The Warren-Edmonson-Butler County Medical Society met for its monthly dinner meeting on March 18, 1952, at the Helm Hotel in Bowling Green. Mr. D. W. Hall, Administrator of the City Hospital, spoke concerning the critical nursing shortage at our local institution. The Society voted in favor of a pay raise for the nurses to bring the pay scale to a level comparable to similar size hospitals.

The Telephone Seminar was enjoyed a great deal and thought to be very excellent.

Frank H. Moore, M. D., Secretary



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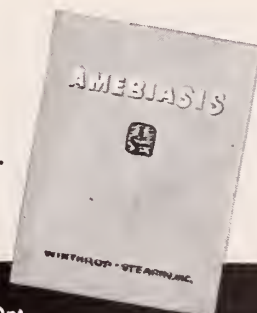
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1. Lindsay, A. E., Gossard, W. H., and Chapman, J. S.: *Dis. Chest*, 20:533, Nov., 1951.
2. Canon, N. J., Jr.: *Am. Jaur. Med.*, 6:309, Mar., 1949.
3. Emmett, J.: *J.A.M.A.*, 141:22, Sept. 3, 1949.

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News Items

R. Arnold Griswold, M. D., has resigned, effective July 1, 1952, as Professor and Head of the Department of Surgery at the University of Louisville School of Medicine, a position he has held continuously since 1938. Dr. Griswold is limiting himself to the private practice of surgery and will be located in the Heyburn Building, Louisville. During World War II, Dr. Griswold served as Consultant in Surgery Fourth Service Command and as Chief of Surgical Service, Walter Reed General Hospital, Washington, D. C.

Robert P. Ball, M. D., of Baton Rouge, Louisiana, formerly of Harlan, was named Vice-President of the American College of Radiology at a meeting recently in Chicago.

Malcolm Barnes, M. D., Louisville, has been elected President of the Kentucky Society of Pathologists for the year 1952. Dr. Barnes received his A. B. degree from the University of Kentucky in 1931 and his M. D. degree from the University of Louisville School of Medicine in 1935.

In Memoriam

WALTER ROSCOE CUNDIFF, M. D.

Somerset

1872 - 1952

Dr. Walter R. Cundiff who was born in Pulaski County November 12, 1872, died February 15, 1952, at Somerset. In young manhood he taught school in Pulaski County and later served as telegraph operator for the Southern Railroad, saving up enough money to attend medical school. He graduated from the Hospital College of Medicine, Louisville, July 30, 1907. He did postgraduate work at New Orleans Polyclinic, New Orleans; Mayo Clinic, Rochester, Minn.; and the Chicago Eye, Ear, Nose and Throat Clinic, Chicago, Ill.

He was past president of the Pulaski County Medical Society and was formerly connected with the Stearns Lumber Company. He was well known throughout the county for his generosity and his gentle, sympathetic manner among his patients and he never refused a call even in the late years of his life.

BOOK REVIEWS

TEXTBOOK OF CLINICAL PARASITOLOGY by David L. Belding, M. D., Professor of Bacteriology and Experimental Pathology, Emeritus, Boston University School of Medicine. Second Edition. Appleton-Century-Crofts, Inc., New York 1, N. Y., Publishers.

This book is designed for medical students, physicians, medical personnel in the armed services, public health officials, laboratory

workers, and biologists. It describes the protozoan, helminthic, and arthropod parasites of man and the diagnosis, treatment, and prevention of the diseases that they produce.

Many additional tables and grafts have been added to this volume.

TEXTBOOK OF CLINICAL PATHOLOGY by Seward E. Miller, M. D., Medical Director, United States Public Health Service; Chief, Division of Occupational Health, Washington, D. C. The Williams & Wilkins Company, Baltimore 2, Md., Publishers. Price \$9.00.

This fourth edition has been completely redesigned, emphasizing the basic scientific facts, interpretation, and evaluation of laboratory diagnostic procedures.

The chapter on hematology and blood chemistry has been entirely rewritten.

This new fourth edition has been designed to give the medical student, intern, resident, physician, clinical pathologist, and teacher of clinical medicine one authentic source of basic scientific information.

LIVING IN BALANCE by Frank S. Caprio, M. D., member of the American Psychiatric Association; Society for the Advancement of Psychotherapy; St. Elizabeths Medical Society; Washington Psychiatric Society; American Association for the Advancement of Science; Delegate to the International Mental Health Congress, London, England. The Arundel Press, Inc., Washington 13, D. C., Publishers. Price \$3.75.

This book gives you a tested, specific plan for understanding yourself and other people about you. It gives medically sound and psychiatrically proved explanations of why we behave and mis-behave as we do—from infancy through adolescence and adult life.

The JOURNAL *of the*

Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 50

JUNE, 1952

NO. 6

Doctors Are Citizens, Too

R. B. CHRISMAN, M. D.

Miami, Florida

As a native Kentuckian, I am deeply grateful for the privilege of being with you during this centennial session of your state medical association.

Kentucky may rightfully be proud of the tremendous contributions made in all the sciences, and especially in its aggressive medical progress.

From your midst has arisen a name which is revered by physicians everywhere. I speak of Doctor Ephraim McDowell, "the father of ovariectomy." You have chosen wisely in paying tribute to him on this occasion.

In medicine, Kentucky has a proud heritage—a proud tradition. This great state has produced seven presidents of the American Medical Association: Dr. Henry Miller was the first in 1859; the last, our own Dr. Elmer Lee Henderson, the immediate past president, almost 100 years later.

In the years to follow, you will furnish more. And so, it is obvious that we have inherited a brilliant history in Kentucky medicine. I know its future will be even brighter.

You know, doctors are primarily scientists; they're physicians *BUT they are also citizens*. Yes, "DOCTORS ARE CITIZENS, TOO." As such, they have many rights and privileges; *YET*, they have certain obligations, certain duties, and certain responsibilities.

A few days ago, I was rather startled to hear one of my young Florida colleagues say that he thought doctors should have nothing to do with politics—that he considered politics "DIRTY."

In time to hear his statement was an older physician who said,

"Do you vote?"

The answer was, "Yes, I vote."

Then the older gentleman replied, "Doctor, VOTING is the very heart of politics, and politics is just as clean as the voters make it."—WITHOUT DENIAL, A TRUE STATEMENT.

Some politicians may be a bit tainted, but not politics itself—which, after all, is merely Government in Operation.

Whether we like it or not, ladies and gentlemen, we're in politics.

In a letter from a former American Medical Association president, I quote:

"We didn't make the decision to enter politics—it was forced on us. But now we are in to stay, if we are to help preserve the freedoms in any of our lives or professions."

I believe Dr. Shoulders is right. If we are to help preserve those freedoms, we must take an active part in our government—we must enter into the civic activities of our communities, our counties, our states. *AND* we must pay more attention to what is going on in Washington.

As physicians, *how* can we *best* play our part?

Read before the Ephraim McDowell Memorial Meeting, the Centennial of the Kentucky State Medical Association, Louisville, October 2-5, 1951.

As I see it, by INDIVIDUAL ACTIVITY AND THROUGH COLLECTIVE ACTIVITY.

Members of our profession have become rather well known as being individualistic. I suppose we *are* individualistic. As such, each man's contribution will vary as he understands his obligation.

Too often, we have been unnecessarily timid in this individual effort. We have had the mistaken idea that there was something faintly unethical about taking the lead in public affairs and civic projects. Some, no doubt, feared criticism by their fellow physicians.

While we don't *vote* every day, we do have the opportunity of exercising our individual citizenship in other ways. We practice good *medicine* every day and we can practice good *citizenship* every day by service to our churches, to our schools, to our clubs, to our families, and in contributing both individual effort and money to all worthy causes—It may be costly, BUT *so are our freedoms costly*.

Some doctors, at great personal sacrifice, offer themselves as servants of the people in their government. Yes, as mayors, councilmen or as state legislators. A bit unusual, perhaps, is the fact that today six doctors, four Republicans and two Democrats, sit in the United States House of Representatives, elected by their people at home.

One of these doctors has said that his colleagues have looked upon him as a freak because he chose to occupy this seat in the Congress.

If we do not feel our duty carries us this far, I say to you:

It is our duty to see that we place in the elective offices of our land, honest and able men who will honestly and ably represent us.

Permit me to tell you about a man in Ocala, Florida. He's a doctor of medicine. If you had watched him at work through the years, you would have seen him marking off a ball diamond at a community camp for children; you would have seen him as Mayor of his town for the third term; you would have seen him on the speakers' stand when his town's new hospital was dedicated—sitting there as a physician AND as a citizen who believes that politics is only good citizenship in action. Also, you would have seen him at the state capitol studying and working for the right legislation.

Most often, you would have noticed him devoting his time and outward efforts to the practice of medicine, listening to and treating each patient as an individual and as a friend, NOT as a walking set of symptoms.

YES, Eugene Peek is a good doctor AND a good citizen.

This man lives in *your* state, too. In Kentucky he has a different name, but he's the same kind of doctor and the same kind of a citizen. From its ranks, medicine can and SHOULD produce thousands of these *individual* leaders.

Now, what about COLLECTIVE ACTIVITY? In our country individuals who band together for good purposes get good results. Since we have been accused of being clannish both socially and professionally, it seems only natural that we could work well collectively.—In fact, I know people who have felt that the old Cabot-Lowell refrain could well be translated to mean that,

"The sick speak only to the doctors and the doctors speak only to each other."

Well, about three years ago, doctors all over this nation really did begin to speak to each other. They also spoke to other professions, to the business man, the laborer, and *all* began to take an alarmed view of the increasing efforts being made to socialize our country. More and more bills were being considered, some were passed, to substitute Federal control for the free enterprise system which has made us the strongest and greatest nation in the world.

The bureaucrats chose two basic necessities of life as their first targets: Health and Housing. They made progress and they made it very fast. Our profession along with others, faced the immediate necessity for quick action, collective action.

In our already organized associations and societies, we were limited legally from any great participation. It became necessary to activate ourselves as individuals, under another banner. We faced a new business realizing we were amateurs, BUT we proved that we could band together; we proved that we could work toward a common objective; *and* we learned that WE COULD WIN.

In state after state, when the votes were counted, the influence of physicians working collectively was manifest in the results. Indeed, we did not accomplish this

alone. We had lots of friends—we were supported by our allies, our neighbors, our patients, and above all, by our wives.

In one town of over 300,000, doctors' wives and their close friends made personal visits of appeal to the home of every registered voter. On election day, they telephoned every name in the book.

As is always the case, some activities were more spectacular than others. Some doctors even hired planes to drop leaflets; others arranged ambulance service for bedridden voters; and many doctors made it a habit of asking every patient if he or she was registered to vote.

Defeated candidates were rather stunned at the awakening of physicians and more than one was quoted as saying:

"No candidate running for office will *ever again* discount the power and influence of physicians."

As you know, Florida had a very colorful senatorial race last year. The activities of that campaign taught us a lot of things:

First, we realized a need for earlier organization.

Second, we found need for more closely knit groups in each county and city.

Third, we saw the value of a permanent committee, outside of so-called organized medicine, ready and willing to work at all times.

So, as soon as the doctors of Florida could capitalize on these needs and on their many experiences, an organization was born with the name of "THE FLORIDA MEDICAL COMMITTEE FOR BETTER GOVERNMENT."

This collective, representative and democratic group elected officers and chose an Executive Board.

The members drew up aims and objectives, some of which I would like to call to your attention:

The Committee is non-profit and non-partisan.

It is permanent and state-wide in scope and is set up completely independent of

organized medicine at national, state and county levels.

It is open for membership to every licensed doctor of medicine and his wife within the state.

It is democratic and geographically representative.

It desires to uphold the traditions of independent liberty and the system of free enterprise.

It attempts constantly to encourage and stimulate physicians and their wives toward better and more active citizenship.

It attempts to cooperate with similar committees whose purposes are in harmony with the aims of this body.

It studies the issues of government, records and platforms of candidates aspiring to state and national offices, and makes this information publicly available.

Today, there are over 1200 members of this Committee.

On next Sunday in Miami, the group will hold its second annual meeting. At this time we shall have the honor to present Dr. John W. Cline, president of the American Medical Association, not only to physicians and their wives, but to the entire public at an open meeting in our city auditorium.

IN CLOSING, may I say that much remains to be done, in Florida, as here, and elsewhere. The challenges of the future and 1952, in particular, are clear, yet complex.

We will continue to prove, I believe, that collective action by civic-minded physicians is effective.

If we can continue permanent, and with unabated enthusiasm, I know that we shall assume our share of responsibility in the preservation of the freedoms which we hold so dear.

May it be our aim, individually and collectively, to practice good medicine and to practice good citizenship. Yes, "DOCTORS ARE CITIZENS, TOO."

Relapsing Pancreatitis

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Relapsing pancreatitis is a clinical entity characterized by recurring attacks of upper abdominal pain of variable frequency, severity and duration.^{1,2} It is usually severe enough to require repeated injections of an opiate to control the seizures of pain, during which there is characteristically an increased concentration of amylase or lipase or both in the blood serum. In the later stages of the disease, after extensive damage to the pancreas has occurred, such increased concentration of enzymes may not appear. After a variable lapse of time there may result such complications as diabetes mellitus, pancreatic calcification, pseudocysts, steatorrhea, creatorrhea and pancreatic abscess.

Relapsing pancreatitis is being recognized more frequently than formerly owing to an increased index of suspicion among physicians, with the result that blood is drawn for determination of serum amylase and lipase concentrations in patients during episodes of acute upper abdominal pain.

Males are affected roughly from three to six times as often as females.^{1,2} The reason for this difference is unknown. The disease may appear at almost any age. My colleagues and I have seen it at ages varying from 10 to 75 years. We have observed it most commonly in the fourth and fifth decades, the average age at onset being approximately 39 years.^{1,2} In one series of cases,¹ it was observed to appear before the age of 30 years in 34 per cent of the cases. It thus tends to produce symptoms at an earlier age than that of the usual patient with cholelithiasis, which it simulates more closely than any other disease.

Etiologic Factors

The cause of relapsing pancreatitis is obscure. There are likely multiple factors but the infectious element seems insignificant in most cases. The theory of regurgitation of bile and duodenal contents into the pancreatic ducts is the most widely accepted single one, since pancreatitis can be induced experimentally by injecting bile into the pancreatic ducts,

and since measures designed to reduce intracholedochal pressure have been followed by relief of the attacks in a fair number of cases. It may be that there is a certain element of choledochoduodenal dyskinesia peculiar to these individuals which may give rise to the attacks.

It is well known that alcoholism may be an etiologic or provocative factor since the disease has been noted rather frequently among those who use alcohol chronically or excessively.

There seems little doubt that calculous cholecystic disease may be of etiologic importance in some individuals. This is a logical assumption since removal of the diseased gallbladder has been followed by cessation of the attacks in many instances. My colleagues and I have noted gallstones in approximately 50 per cent of the cases of relapsing pancreatitis studied.^{1,2} There is some reason to suspect that in certain instances cholecystic disease may result from the repeated inflammation which accompanies relapsing pancreatitis.²

Direct trauma over the pancreas has been known to result in pancreatitis. In this connection the speaker saw 1 case of relapsing pancreatitis of great severity in which the initial attack followed immediately a blow across the epigastrium.

Large, greasy meals as well as nervous and physical stress have been blamed by some patients as provocative factors.

Symptoms

The most important symptom of relapsing pancreatitis is the recurrent episodes of upper abdominal pain.^{1,2} This pain can be relatively mild, may last only a few hours, and may involve almost any part of the abdomen. More commonly the pain is severe, may be protracted for days and may require multiple hypodermic injections of morphine. The duration of the painful attacks is variable (table 1). Pain may spread from the upper to the lower part of the abdomen and around into the upper lumbar region of the back. At times it may be limited to the right upper part of the abdomen and corresponding level in the back, in which case it may be confused with gallstone colic. It may be referred to the an-

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Table 1

Duration of Pain in 29 Cases
of Chronic Relapsing Pancreatitis*

Duration of pain	Cases
Less than 1 hour	1
1-5 hours	2
6-11 hours	1
12-23 hours	1
2-6 days	6
7-13 days	7
14-20 days	1
21-27 days	2
28-35 days	6
Not determined	2

* Reproduced with permission from Gambill, E. E., Baggenstoss, A. H., Comfort, M. W., Sprague, R. G. and Waugh, J. M.: Proc. Staff Meet., Mayo Clin. 22:537-560 (Nov. 26) 1947.

terior part of the chest and the shoulders. It is most characteristic when it shifts to, or is of maximal intensity in, the left upper part of the abdomen and left upper lumbar region of the back. It is most often gradual in onset and cessation and tends to be steady but there may be superimposed waves of exaggeration. The pain may be described as piercing, burning, colicky, cramping, cutting or boring.

The attacks often become increasingly frequent, severe and prolonged, but the opposite may occur.

Occasionally patients experience, for a few hours or days prior to the attack, prodromal symptoms such as nausea, anorexia, weakness and flatulence.

Numerous symptoms accompany the pain. There is often nausea and vomiting, the latter sometimes affording partial and evanescent relief. Retention vomiting may occur due to duodenal obstruction or ileus. Generalized abdominal distention, the inability to belch or pass flatus and the feeling that all gastrointestinal activity ceases is common, owing to adynamic ileus. The return of borborygmi and the passage of flatus may

herald the cessation of pain. The entire abdomen is often tender, maximally in the upper part, so that coughing, sneezing and turning in bed may be done with reluctance. Tenderness, anorexia and weakness may persist for days after cessation of pain. Obstipation is the rule.

In the intervals between the acute episodes patients may be symptom free or present varied complaints none of which are diagnostic of pancreatitis. Among these are flatulent dyspepsia, heartburn, vague epigastric pain and weakness.

Fatty, voluminous, malodorous stools characteristic of steatorrhea may occur in which case loss of weight and strength are noted.

Physical Signs

Between the attacks of pain there may be no physical signs, though epigastric tenderness is not uncommon. Pancreatic cysts are usually palpable. During the acute attack there is generalized abdominal tenderness of the direct and rebound type, maximal in the epigastrium. Muscle guarding and spasm are common. The swollen, tender pancreas can sometimes be felt lying transversely in the epigastrium. The more severe attacks may present findings suggesting generalized peritonitis with ileus, distention, tachycardia, fever, ascites and even mild shock. A dilated stomach with splashy contents may be demonstrated. The patient may lie quietly in bed, reluctant to move or breathe deeply, or he may sit up with trunk flexed and the arms folded tightly across the abdomen. Occasionally the liver and spleen may be enlarged and there may be mild icterus. High fever and chills are not characteristic.

Laboratory Aspects

Only those laboratory findings which have a diagnostic bearing will be mentioned. Except for glycosuria, urinary findings are not helpful. The most valuable laboratory aid is the finding of increased concentrations of amylase and lipase in the blood serum during the acute seizures. These values revert to normal soon after the cessation of pain. Increased values for these enzymes may not appear if the pancreas has been sufficiently damaged.

During the attack a mild degree of hyperbilirubinemia may appear. In the presence of fat necrosis the concentration of calcium in the serum may be decreased. This may be a prognostic aid, according

to Edmondson and Berne,³ who have said that values below 7 mg. per 100 cc. of blood are usually followed by death. In a fatal attack in one patient observed by my colleagues and myself,⁴ the concentration of serum calcium was 5.5 mg. per 100 cc. At necropsy tremendous amounts of calcium and phosphorus were present in the sites of fat necrosis both inside and outside the pancreas (table 2).

Table 2
Concentration of Calcium and Phosphorus in Pancreatic and
Omental Tissue in a Case of Acute Hemorrhagic Pancreatitis
With Disseminated Fat Necrosis*

Tissue	Mg. per 100 gm. of tissue (wet weight)	
	Calcium	Phosphorus
Head of pancreas (nonhemorrhagic)	46.7	192.0
Body of pancreas (hemorrhagic)	131.7	54.2
Omental fat (without necrosis)	41.9	32.1
Omental fat (area of necrosis)	261.0	66.0

* Reproduced with permission from Gambill, E. E., Baggenstoss, A. H., Van Patter, W. G. and Power, M. H.: *Gastroenterology*. 11:371-381 (Sept.) 1948.

Steatorrhea, suspected in the presence of voluminous, greasy, malodorous stools, may be confirmed by chemical determination of the fat content of the stool—preferably by using a twenty-four to forty-eight-hour specimen collected while the patient's diet contains approximately 100 gm. of fat a day.

While the secretion test may be useful in detecting deficiency of external pancreatic secretion, its use is not often necessary for the diagnosis of pancreatitis.

The fasting gastric contents may be abnormally increased in acute pancreatitis owing to duodenal obstruction or ileus.

A simple roentgenogram of the abdomen may disclose calcific deposits, either localized or diffuse, in the pancreatic region. Cholecystograms taken soon after an attack of pancreatitis may reveal no function or poor function of the gallbladder due to cholecystic disease, pancreatitis, or both. Roentgenologic studies of the stomach and duodenum made with the aid of barium may reveal gastric dilatation, widening of the duodenal loop, hypomotility and even ulcer-like deformity of the duodenum, the result of adhesions or pressure.

Complications

Pancreatic calcification may appear in perhaps a third to a half of the cases of

relapsing pancreatitis.^{1,2,5} This has been observed as early as a year and as late as ten to twenty years after the first episode of pain⁵ (table 3). The extent of calcification does not necessarily parallel the severity of the disease, since there may be extensive calcification without any evidence of disturbed pancreatic function⁵. However, pancreatic steatorrhea and diabetes mellitus are much more common in pancreatitis with calcification than in pancreatitis without calcification⁵ (table 4).

Diabetes mellitus, commonly mild, may eventually appear in 15 to 20 per cent of cases of relapsing pancreatitis.^{1,2} Steatorrhea may appear as an eventual complication in 25 to 30 per cent of cases and may be associated with considerable loss of weight.^{1,2} Inflammatory pseudocysts of the pancreas have been observed in 10 to 15 per cent of individuals with relapsing pancreatitis.^{1,2} These cysts may be single or multiple and may contain high concentrations of pancreatic enzymes.

Table 3

Years Between Onset of Attacks of Severe Pain and
the Discovery of Pancreatic Calcification,
Diabetes Mellitus and Steatorrhea*†

Years	Calcification, cases	Diabetes, cases	Steatorrhea, cases
1	8	3	1
2 to 10	17	3	4
11 to 22	8	3	2
Unknown	2	0	0
No pain	4	0	0

* Based on 39 cases of pancreatic calcification.

† Reproduced with permission from Gambill, E. E., and Pugh, D. G.: *Arch. Int. Med.* 81:301-315 (Mar.) 1948.

Table 4

Incidence of Diabetes and Steatorrhea in Cases of Pancreatic
Calcification With and Without a History of Pancreatitis*†

History of pancreatitis	Pancreatic calcification, cases	Diabetes		Steatorrhea	
		Cases	Per cent	Cases	Per cent
Positive	22	9	41	7	32
Negative or doubtful	17	0	0	0	0

* Based on 39 cases of pancreatic calcification.

† Reproduced with permission from Gambill, E. E., and Pugh, D. G.: *Arch. Int. Med.* 81:301-315 (Mar.) 1948.

Diagnosis

As in other diseases, the first prerequisite to the diagnosis of pancreatitis is to think of the possibility. When the history is sufficiently typical, an accurate diagnosis can often be presumed on this basis alone. Actual proof of the diagnosis will rest on demonstration of increased concentration of enzymes in the serum or disturbance in pancreatic function, or on examination of pancreatic tissue.

The following criteria are useful in the diagnosis of relapsing pancreatitis. A history of recurrent attacks of severe pain in the upper part of the abdomen during the course of which steatorrhea, diabetes mellitus or pancreatic calcification develops is strong evidence of pancreatitis, provided antecedent diabetes and other causes of steatorrhea can be excluded.

In the absence of these complications the diagnosis has to be made on the basis of the recurrent nature of the attacks, the severe and prolonged pain, the exclusion of other causes for pain and the finding of increased concentration of lipase or amylase in the serum. The chief conditions which must be differentiated are acute myocardial infarction, acute cholecystitis and its complications, acutely perforated viscus with peritonitis, as from gastric or duodenal ulcer, peritonitis, thrombosis of the mesenteric vessels and acute intestinal obstruction. Without going into detail, suffice it to say that a careful history and physical examination and appropriate laboratory aids will usually permit the correct diagnosis.

Pancreatitis is most difficult to diagnose when the attacks are relatively mild, the pain is in an atypical location and there are no evidences of complications. The recurrent nature of the attacks and the finding of increased concentration of pancreatic enzymes in the serum during an acute attack lead one to the correct diagnosis. The enzymes are not increased if the pancreas is severely damaged. Sometimes a false increase in concentration of serum enzymes may occur after injection of an opiate or in the presence of perforated peptic ulcer. The policy of suspecting pancreatitis in anyone suffering from recurrent attacks of epigastric pain and of obtaining a sample of blood for determination of serum amylase and lipase during or soon after the attack should result in recognition of the disease

more commonly than has happened to date.

Treatment

The treatment of relapsing pancreatitis is far from satisfactory; none is specific. Medically one tries to (1) institute preventive measures, (2) provide palliative treatment for the acute seizures and (3) employ dietary and substitution therapy for certain complications.

Although there is no definite way of preventing the attack, the use of alcohol in all forms should be forbidden for reasons previously cited. These patients should reduce, if overweight, and should abstain from eating large, greasy meals. The avoidance of excessive nervous and physical stress and trauma over the pancreas is logical.

For the acute seizure opiates and other drugs are employed for the pain. Ephedrine, atropine and related drugs have been used on empirical grounds. Dehydration, electrolytic imbalance and shock are treated by the use of glucose by vein, sodium chloride and other electrolytes, vitamins, amino acids, blood by transfusion as indicated and other appropriate measures. Gastric and intestinal distention and ileus are treated by means of aspirations, hot stupes and a rectal tube.

Sequelae such as diabetes mellitus and steatorrhea are treated by appropriate diet and replacement therapy in the form of insulin for diabetes and pancreatin for the steatorrhea. Doses of 2 to 10 gm. of pancreatin given three times a day along with moderately restricted intake of fat reduce the loss of fat in the feces.

Surgical treatment seems to have more to offer than does medical treatment. Surgical measures for relapsing pancreatitis are indicated as (1) an effort to arrest the recurrent attacks and thus prevent progressive loss of pancreatic function, (2) to drain pancreatic abscesses and pseudocysts, (3) to relieve obstruction of the duodenum and common bile ducts, (4) to remove calcific masses which may be obstructing the exit of the larger pancreatic ducts and (5) to relieve the patient of frequent or chronic disabling pain.

The consensus is that surgical treatment should be avoided during the acute phase of the disease unless special circumstances, such as the need for drainage of an abscess, require it. Ordinarily it is best to postpone operative measures until the

concentration of serum amylase and lipase and the temperature have returned to normal, and until the signs of an acute abdominal condition have abated.

The large number of surgical procedures employed to date attest to the fact that the ideal procedure has not been found. Prolonged drainage of the common bile duct either externally by means of a T tube for at least six to twelve months or internal drainage by means of choledochoduodenostomy were employed with apparent success in perhaps a half to two thirds of a series of cases.^{1,2} More recently,⁶ endocholedochal sphincterotomy has been advocated but more time will need to elapse to evaluate this and other forms of surgical treatment. Splanchnic block has been advocated to relieve the pain of the acute attacks.

Sympathectomy has been done with variable results in the relief of pain.⁷⁻¹⁰ The speaker feels that this operation should not be employed as a primary procedure, since it likely does not arrest the destructive process in the pancreas. It seems wisest that the diagnosis first be confirmed by abdominal exploration, at which time the common duct and pancreas can be explored and the gallbladder removed if it is diseased. Prolonged drainage of the common bile duct can be instituted and, if this is not effective, then sympathectomy can be considered at a later date.

Partial gastrectomy¹¹ has been employed for relapsing pancreatitis but more time and more extensive use will have to decide its worth.

Partial pancreatectomy has been performed whenever the disease is localized to one part of the pancreas and whenever more conservative measures here failed.

My colleagues and I believe that the more conservative operations should be tried first. Total pancreatectomy is rarely done as it is difficult and carries a high mortality. It should be considered only after conservative procedures have failed and the patient is invalidated by extensive disease of the pancreas with intractable pain and virtual loss of all pancreatic function. Unfortunately by the time this stage is reached patients are often addicted to morphine and alcohol and therefore are most difficult to evaluate or to treat successfully by any means.

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Tropical Diseases in the Southwest Pacific Area

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It would seem fitting and possibly timely at this centennial meeting to discuss and review some of the diseases we saw and some of the lessons we learned in tropical diseases in World War II.

On this occasion it is well to point out that many fine contributions to military and tropical medicine during World Wars I and II have been made by Kentucky doctors.

Our understanding and knowledge of tropical medicine has, within the last decade, undergone a considerable change. Diseases that not too long ago were of little more than academic interest have become important to us. To a large extent this change can be attributed to our military campaigns in the Southwest Pacific during the last war. Today, when our Armed Forces are once again fighting in tropical areas, tropical medicine assumes a prime importance.

This discussion will deal with some observations of the diseases that existed during the Pacific campaigns; their occurrence, characteristics, modes of transmission, control and prevention. In particular we shall consider New Guinea, the Philippine Islands, Japan, Okinawa and Korea.

In the fall of 1944 the author was assigned as commanding officer of the 19th Medical General Laboratory at Hollandia, New Guinea, later re-designated the 3rd Medical General Laboratory in the Philippines. At this same time he was designated as laboratory consultant for the Southwest Pacific. The 19th MGL was one of the four medical general laboratories organized during the last war for the general purpose of studying the epidemiology of the diseases of the theatre in which it was located and any other special medical problems that might arise.

The diseases of greatest interest and importance among our troops and in the native population of *New Guinea* were probably malaria, atypical lichen planus, scrub typhus, hepatitis, dengue fever, yaws, various skin diseases, and diphtheria.

The diseases of the *Philippine Islands*

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that were of major importance were poliomyelitis, three-day fever, bacillary dysentery, amoebic dysentery, schistosomiasis, hookworm and tuberculosis.

The diseases of significance in *Japan*, *Okinawa*, and *Korea* were cholera, Japanese B encephalitis, epidemic typhus fever, smallpox and leprosy.

Diseases of New Guinea—Malaria

As is well-known to everyone here, malaria was without question our number one problem in the early phases of the Southwest Pacific campaign.⁶⁵

Even though the facilities to combat malaria were at hand our Army had not yet been indoctrinated and disciplined in the fundamentals of malaria control. Therefore, our first divisions were practically decimated before we could institute a program of mosquito control and drug prophylaxis.⁴¹ Even though atabrine was available, many of the troops and their officers did not take the drug, considering the whole thing a joke and further the idea was rather widespread that atabrine would make them impotent.

Tertian malaria was the type most prevalent⁵⁴ and the natives constituted an ever-present reservoir which extended all the way from New Guinea to Korea, where today in the southern part of Korea, it is still a real problem.²⁵ The vector of malaria in New Guinea, *Anopheles punctulatus punctulatus*, was attacked and controlled within one-half mile of all troops by the units themselves and through the assistance of Malaria Survey and Control Units. All military personnel before going overseas were given a certain number of hours of careful training in atabrine prophylaxis (0.1 gm daily) and other personal protection instructions.

By the time our unit arrived in New Guinea, July 1944, there was a high state of education, indoctrination and the instinct to do that which was right in the control of malaria. Discipline in the observance of control measures was accepted almost universally among everyone there which resulted in a low rate of malaria.⁶⁰

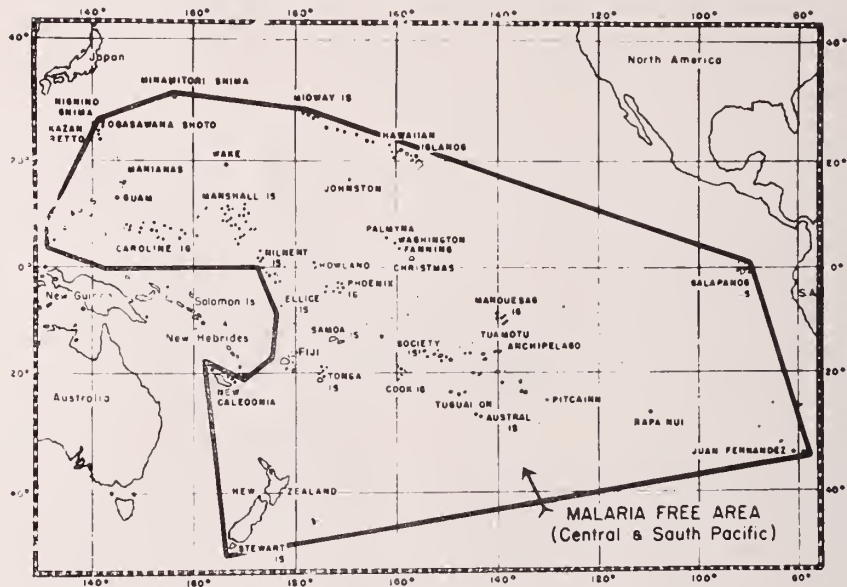


Fig. 1. Malarial and malaria free areas of the Pacific Ocean.

Atabrine was very effective in the suppression of the symptoms of fever, chills, etc., and by long careful research studies we were not able to find any organisms in the peripheral blood. Apparently the trophozoites are not all destroyed for in cases of heavy exposure there was a tendency to recur. In the Pacific area, the recurrences were as high as 15 to 20 times whereas in the Mediterranean theatre about seven times was the average among recurring cases.

No cases of cerebral malaria or black water fever were seen in our personnel. The atabrine effectively controlled the estivo-autumnal or falciparum malaria.

Severe cases did occur occasionally and were effectively treated by the use of blood transfusions and intramuscular inoculations of atabrine. The liberal use of whole blood was one of the lessons we learned in the treatment of cases where the red blood cells are heavily infected. Some cases showed almost all of the erythrocytes to be parasitized. Chloroquine⁶³ and paludrine were just being developed at the end of the war.

Our laboratory set up a controlled study of the use of chloroquine in a Philippine "barrio" or village not far from Manila. A very high spleen and positive peripheral blood smear rate existed. Every other person in the village was given chloroquine and no effort was made to control the *Anopheles minimum flavirostris*, the vector there. One tablet (0.1 gm) per

week was given of the so-called "white atabrine" and the falciparum (estivo-autumnal) malaria was entirely controlled. Vivax malaria was almost completely suppressed by the atabrine prophylaxis. The results appeared to be very good as long as the prophylaxis was continued.

Atypical Lichen Planus

There occurred on New Guinea a most unusual condition, a skin sensitivity reaction which has rarely been seen before, known as "jungle rot" to the men. It occurred exclusively in American military personnel and specifically only in those who had been taking atabrine. Considerable numbers of individuals were af-



Fig. 2. Malaria Control and Survey Unit in New Guinea. Largely as a result of the commendable work of such units, the malaria problem in the Southwest Pacific Area was effectively controlled during the latter part of the Pacific campaign. (Photograph through courtesy of U. S. Signal Corps.)

fected and at one time there was an estimated incidence of 10% among our men. I recall seeing six hundred cases all at one time in the hospitals near our laboratory. The men, for some reason, did not develop this syndrome until they had been in the tropics for from 4 to 6 months.

We noted that in every case of this condition which was named "atypical lichen planus" the individual had been using atabrine regularly. The syndrome rarely appeared in those not using atabrine.

This widespread occurrence is not to be confused with the common lichen planus of temperate regions. The lesions were hypertrophic and would become confluent forming thickened elevated patches, blue or violet in color and flat-topped. There was a bilateral involvement of the hands, legs, inguinal regions, neck, eyelids and fingernails. A few cases were quite severe and developed a complete exfoliation of the epidermis while others developed an aplastic anemia and died. Mild cases were treated while the individual remained on duty by the use of bis-muth salicylate (2 cc) injected intramuscularly once each week. One of the methods of treatment of the severe cases was to give the patient oatmeal baths constructed from belly tanks of airplanes. This treatment had a mitigating effect in some cases.



Fig. 3. A typical case of atypical lichen planus. The bilateral involvement first suggested that this was due to an allergic sensitivity. (Photograph through courtesy of the Armed Forces Institute of Pathology, Washington, D. C.)

It was concluded that atabrine hypersensitivity was the cause of this unusual condition, but that it was far more important to our war effort to suppress malaria than it was to eliminate atabrine sensitivity. Chloroquine prophylaxis so far has not produced this syndrome.

As a rule recovery followed discontinuance of atabrine prophylaxis although there have been a few cases reported where the lesions are even yet persisting.

Scrub Typhus Fever

A disease in New Guinea that was second in importance only to malaria was scrub typhus fever⁷⁸ known to the natives as "mokka." It was only a few years ago that this disease was recognized to be identical with tsutsugamushi fever of Japan. Although New Guinea was the most important area (of those we are discussing) for this disease, there was also a high rate in India and Burma.

Its main vectors in New Guinea were the larvae of the mites *Trombicula akamushi* and *Trombicula deliensis*. The causative agent, *Rickettsia tsutsugamushi*, passed from infected rats which served as a reservoir to the larval mites. The mites were often found in debris and in a type of tall grass called "kunai grass." Man became infected when his blood was aspirated by an infected larval mite. The mite acquired the infection either from a rat or from its parents via the egg.

Among the main diagnostic findings in a typical case were an "eschar," rash, enlarged spleen and lymph nodes. Diagnosis also included the results of a Proteus OXK agglutination test which was a specific test for the disease.⁶⁷

Among the control measures that we used were impregnating clothes with dibutyl thallate and clearing or burning areas of grass and debris where mites were to be found. While, at that time, we had no effective acaricides or vaccines, since then acaricides have been developed and commendable work by Smadel, Traub, and Frick has been done with chloramphenicol used both as a prophylactic and as a therapeutic agent.^{66,72} Its use is still being investigated. Chloramphenicol, aureomycin, and terramycin are rickettsiostatic, though relapses will occur if therapy is stopped before a sufficient antibody titer is established.

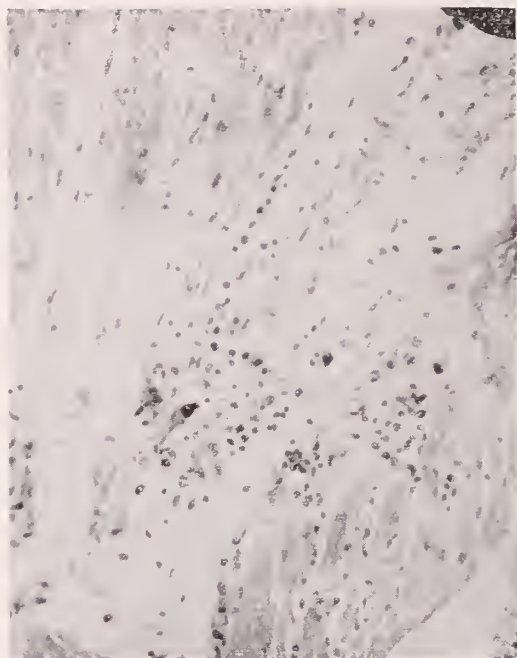


Fig. 4. Section of the heart in a case of scrub typhus fever.

Infectious Hepatitis

A major problem in New Guinea and the Philippines was infectious hepatitis which seemed to be a problem of military rather than civilian life.¹ One of our sharpest and largest outbreaks was one that I recall which occurred on the island of Biak near New Guinea. We found the incubation period of the acute form of this disease to be about 18 days.^{23,48,49}

Our belief was that the disease was transmitted (under natural circumstances) similar to the way poliomyelitis is transmitted, specifically by contact.^{40,74} Contaminated food and stools were very probably involved. One of the interesting observations that were made was the apparently high correlation between an area's sanitation index and its hepatitis rate. One of the lessons that we learned from experience was the adverse effect on the mortality rate among patients moved any distance either by ambulance or air.^{35,38,55}

There was considerable interest in a reverse complement fixation test which our laboratory investigated in which we used the acute phase sera as the antigen and known convalescent pooled sera as the positive sera. This we were unable to confirm in studies made later in this country.

Dengue Fever

A wonderful opportunity to see dengue fever was presented in New Guinea. The disease was quite prevalent there though it was not found in the Philippines nor in Japan and Okinawa. It is a disease which is usually restricted to areas where it has been characteristically endemic, although sizeable epidemics are by no means unknown.³⁹ The chief vector in New Guinea was a mosquito, *Aedes albopictus*, though elsewhere the main vector is the more widespread species *Aedes aegypti*. The disease is caused by a virus which was isolated during World War II by Sabin and has a low mortality rate. One of its characteristics aside from the fever is a petechial type of rash. It is easily confused with influenza, typhus fever, German measles, rheumatic fever, malaria, and sandfly fever. In patients with dengue, following the fever, there was a marked mental depression in many cases. Fever in some when charted, presented the typical "saddle back" curve. Between the time that a victim was exposed to the disease (infected mosquito sucking blood) and the time of first symptoms there usually was an incubation period of ten days.

Some strain serological research has been done on this disease. Sabin, for example, has demonstrated different serological neutralization strains of the virus. This aided materially in diagnosing some fevers of undetermined origin which we could not explain on any other basis. On the establishment of new bases in New Guinea with the proper mosquito control the dengue rate rapidly dwindled to insignificance. This also was admirably demonstrated by the results of the house-to-house DDT spraying conducted in Manila during its reoccupation. There was no doubt that there dengue fever had been controlled because of the elimination of the *Aedes albopictus* mosquito. Dengue was a very well-known and common disease in the Philippine Islands before World War II and one on which American investigators had made many studies.

Yaws

A disease of medical interest in New Guinea was yaws. It was prevalent in New Guinea more than in any of the other areas under discussion. However, it was a disease of the native islanders exclusive-

ly.²² None of our personnel ever contracted it to my knowledge. Although caused by an organism (*Treponema pertenue*) that is morphologically indistinguishable from the etiological agent of syphilis, yaws differed from the former being definitely nonvenereal and noncongenital and in its being found quite frequently in children. Yaws was not particularly difficult to cure and in general responded to the same class of therapeutic agents that are effective against syphilis.^{37,61} We found penicillin to be adequately effective in the cases treated.

The first case of yaws treated with penicillin in New Guinea was a 6-year-old native boy with the greater part of his scrotum involved with the infection. He was treated with aqueous penicillin in the usual doses and on the second day demonstrated a considerable Herxheimer reaction. The lesion healed with miraculous rapidity. The fortunate outcome of this case aided immeasurably in the epidemiologic studies we desired to make among the natives from that incident on.



Fig. 5. Native boy of New Guinea with typical frambesioform lesions of yaws. Unlike syphilis, yaws was very common in the native Polynesian children.

Blood Bank

In New Guinea and the Philippines there was a great need for blood banks. In response to this need our laboratory established a collecting center in the Philippine Islands which, though very necessary, was

in the light of our present knowledge and the high incidence of hepatitis there, perhaps not a wise thing to do. This is true because probably cases of hepatitis as well as those of the so-called "homologous serum jaundice," probably originated from transfusions of blood donated by individuals that either had these conditions, often in a subclinical form or had a past history of the disease.²¹ Also, maintenance of constant temperature was difficult under field conditions for storage and transportation of the blood. As we do not definitely know how long it is after recovery from these diseases that one's blood remains infective, it is safest to exclude any person who has ever had these conditions from being a blood donor. There are, however, some who feel that this is under certain circumstances too drastic a policy to pursue.

In a few jaundiced patients we believed we were dealing with cases of Weil's disease or some other leptospirosis, though we never positively confirmed these tentative diagnoses.

Tinea Imbricata

Another disease of interest was a skin disease, tinea imbricata, which was frequently seen in the New Guinea natives. The condition is characterized by brown scaly patches in a rosette-like pattern arranged concentrically. The specific name "imbricata" means "shingle-like." It is caused by a fungus, "*Trichophyton concentricum*." The condition readily extended to most parts of the body except the scalp. The disease is probably transmitted by direct contact. It was not seen in American personnel and is said to be present only in the Southwest Pacific area largely among the native population. The pattern of the appearance of this skin disease is so definite and clear cut that once seen is easily recognized. Chrysarobin ointment 2-5% has been reported to be effective.

Tropical Ulcer

Tropical ulcer was a disease of relatively minor importance to the U. S. troops in New Guinea, though it occurred not infrequently among the natives. It should not be confused with "tropical" or oriental sore which is a form of leishmaniasis. Its etiology has never been conclusively demonstrated though *Bacillus fusiformis* and *Spirochaeta vincenti* have long been suspected of being the causative agents.



Fig. 6. *Tinea imbricata*. One of the most commonly seen skin afflictions in the natives of New Guinea. Note the characteristic shingled rosette-like pattern and the extensiveness of the lesions.

In five out of six tropical ulcers in New Guinea virulent diphtheria organisms were isolated. Their significance merits further investigation as they responded readily to topical application of penicillin. These were observed only in the natives and it is probable that if early cuts and abrasions were properly attended they would certainly occur less frequently.

Diphtheria

There were two outbreaks of diphtheria observed in two of the Army hospitals of New Guinea. The diphtheria occurred both in patients as well as in hospital personnel and was of two types, the more familiar being typical pharyngeal diphtheria and the other cutaneous diphtheria. It was noted that the more debilitated individuals developed pharyngeal diphtheria following the occurrence of cutaneous diphtheria ulcers particularly in open hospital wards where contact was close. Control was readily achieved by the administration of diphtheria toxoid in very small divided doses to those who had a Schick positive skin test reaction. Cultures were made for carriers and all positives were treated and observed until culturally negative. In certain areas possibly troops should receive diphtheria active immunization. The presence of diphtheria in the

tropics has been observed before and can be almost as much of a problem as it is in temperate climates.

Poliomyelitis

We next turn to the Philippine Islands and its disease problems. A disease that we found to be a problem in that area was one that ordinarily is not thought of when considering the "tropical" diseases; that illness is poliomyelitis.⁵²

Strange as it may seem poliomyelitis did not occur in our troops or among the civilian population in the Pacific campaign until the first or second day after our troops landed at Leyte in the spring of 1945. For this reason it caused considerable concern when it appeared at that time and place.⁷⁷ We verified the identity of the disease by inoculating material from stool specimens into monkeys which were obtained locally. This method of confirmation did not succeed at first. Approximately one month later I personally carried one refrigerated stool specimen 2,000 miles by plane back to our laboratory in New Guinea and there obtained the first successful reproduction of the disease in a monkey obtained from Australia and definitely established that we were dealing with poliomyelitis.^{28,33} The disease was more prevalent in the American troops than among the native population suggesting that perhaps the Filipinos possessed a high degree of immunity than did our troops.⁴³ When and where the disease did appear, especially in one American division, the mortality rate in the bulbar type was sufficiently high to be a real military problem not only due to the actual occurrence of the disease, but also because of the dread and fear that begins to spread whenever it begins to occur to any degree.

The best preventive measure appeared to be good sanitation in areas where it could be improved. At one time in one division the "monkey pet" that so many "GI's" acquired was thought to be the reservoir, source or carrier of the virus. Our laboratory agreed to examine stool specimens from approximately 75 monkeys that had been pets of the soldiers. It turned out to be a considerable undertaking but all examined were found to be negative.

Specimens from all paralytic cases numbering about 75 were inoculated into monkeys for confirmation and study of

the disease. The monkeys would develop a temperature in 6-10 days after inoculation at the peak of which paralysis of one or more groups of muscles would develop.^{3,7} Stool specimens from cases of so-called 3-day fever that were suspected of being polio were found universally to be negative.

Three-Day Fever

(Clinically similar to Pappataci Fever and Dengue)

Three-day fever appeared to be a new disease of World War II. It occurred in the Philippine Islands and was first observed by medical officers at Fort Stotsenberg and Clark Field. It was characterized by headache, lassitude, a slight rise in temperature, aching and nuchal rigidity.

Laboratory findings revealed an increase in the spinal fluid cell count, chiefly in lymphocytes and polys. At first it was thought to be dengue fever. However, it differed from the classical picture of dengue. The disease it resembled most closely was pappataci fever.⁷⁶ The only discernible difference was that the *Phlebotomus* or sandfly could not be found in rock walls or other places of common habitat by such fine entomologists of our unit as King, Hoogstraal and others.

Soon after its first outbreak it appeared in epidemic form in the troops surrounding Manila including our own unit. This is the first and only recorded epidemic of three-day fever that has been reported.³⁴ Much investigative work was carried out and finally at the Army Medical Service Graduate School it was found that the serum neutralized an encephalomyocarditis virus isolated from a rat in South America. A differential titre was present in paired sera. Although some patients were quite ill there was no mortality. The cells in the spinal fluid and nuchal rigidity made the syndrome resemble abortive polio, but stool specimens inoculated into monkeys were negative while our positive polio cases were almost 100% positive for their infectivity for monkeys and this was controlled by some of the research centers in this country by use of duplicate specimens.

Bacillary Dysentery

One of the most important problems faced by our troops in the tropics was bacillary dysentery. The rate was especially high on new landings. There was

an incubation period of 16 to 18 hours. The dysentery lasted about 5 days. The symptoms included lassitude, cramping and 15 to 20 stools a day. Mucus and blood were present in the stools. The disease was not present in areas where the latrines were well-covered or the men in the field covered excrement. Fly breeding was extremely difficult to control in the battlefield particularly where the fighting was such that the bodies could not be removed or treated readily. This was a definite problem at Leyte. At Okinawa the beachhead was sprayed with DDT before landing. As a result there was a low rate of bacillary dysentery. The low rate was in part due to the admirable work of the Malaria Control Unit in their use of DDT and benzene hexachloride.

A vaccine was developed by General George R. Callender, Army Medical School, Washington, D. C., and used experimentally with controls in one division and our laboratory personnel. We had high hopes for the vaccine but it did not have a protective action against the disease as bacteriologically proven cases occurred among those vaccinated including myself. In the Philippine Islands a tricholera, dysentery, typhoid vaccine was developed and used by the Philippine Public Health authorities. It was claimed that this reduced the death rate in infants. Another prophylactic measure taken was the chlorination of all water. We found that sulfaguanidine was very effective as a therapeutic agent; later sulfadiazine was used instead.

Amoebic Dysentery

There was very little if any detectable amoebic dysentery occurring among the troops during the New Guinea and related island campaigns. It was not until the landing at Leyte that clinical amoebic dysentery began to appear in our troops. It was most prevalent in the Philippine Islands and in Japan though amoebic dysentery in the Philippine Islands seemed to be more virulent than it did elsewhere.^{36,50} Amoebic dysentery is not always apparent at first if it is masked by some other condition such as the more prevalent bacillary dysentery. Extreme weakness is the only presenting symptom in some cases. In a typical case of amoebic dysentery there was weakness and continued diarrhea with mucus and blood in the stools. High rates followed bacillary dysentery outbreaks after landings such as



Fig. 7. American troops wading in a fresh water stream in Tacloban, on the island of Leyte. As a result of such exposure, many contracted schistosomiasis by the penetration of the cercariae through the skin.

Leyte. The life cycle is a simple one. An infected human passes cysts in the feces; food or water is contaminated; cysts are ingested; cysts excyst in the ileum of the small intestine; cysts produced and passed in the feces. Only the cysts it will be recalled are infective. Diagnosis depends upon the actual demonstration of either the trophozoites or the cysts of *Endamoeba histolytica* in the feces.³¹

During this period amoebic dysentery was treated by emetine followed by a course of carbarsone and then diodoquin. Today we use antibiotics such as aureomycin.^{26,44,64,71} The methods of prevention are basically the same as in bacillary dysentery.^{12,13}

Schistosomiasis

Schistosomiasis was first encountered at Leyte in the Philippine Islands. The first case of this disease was diagnosed by Lt. Barksdale, one of the allied science officers in the Bacteriology Department of the 19th Medical General Laboratory. Later *Schistosoma japonica* ova were found in the stools of natives and some local animals (dogs, roosters, caribao, etc.).⁶⁸ This was one disease whose presence was predicted but against which we did not have adequate protection.

Our men contracted the disease when wading in streams or standing in water. In these streams, cercariae, having previously hatched out of ova, penetrated the skin of the host. Approximately five days later, abdominal pains, diarrhea, discomfort and tension appeared. A considerable number of our troops became infected⁴⁵, especially prisoners of war.

The laboratory assisted in the diagnosis

by finding the ova of the schistosoma in the patient's stool specimens.⁷⁵ The eosinophilia was a great aid in the diagnosis of this disease.³⁹

The treatment used was antimony tartrate, ammonium tartrate and fuadin. Since that time we have learned that ammonium tartrate is best.¹⁶ Fuadin appears to stimulate the ovary of the female schistosoma to greater ova production and has not proven to be as good a drug as was once suspected.

High rubber boots were recommended for the men who would have to expose themselves by wading in the streams. You have undoubtedly contacted some of these cases among veterans. The area in which they fought aids materially in making the diagnosis.

Hookworm

Hookworm was found in the natives of New Guinea and the Philippines in some areas as high as 80%. It was contracted by some of our troops as well. The problem was one of the proper disposal of excrement.⁵⁹ The native villagers were the chief source of contamination of the soil. If hookworm ova were present they soon hatched into larvae.

One epidemic occurred in a General Hospital detachment. There were some cases with pneumonia thought to have been brought about by a particularly heavy concentration of larvae in the lungs of the cases. In some patients high eosinophile counts were encountered in which hookworm ova could not be found and which were unexplainable other than to call them "tropical eosinophilia" which is described in the literature.¹¹

The chief problem here was not to introduce into the United States *Ancylostoma duodenale*, the "Old World Hookworm," by returning military personnel. This is the type most resistant to treatment and very undesirable to have established in this country. There was probably some brought back but by maintaining good sanitation it should not have become established or spread to any great degree. We found parasitism in about 80% of Philippine Army Scouts compared to 20% in our own troops.

Japanese B Encephalitis

There are a number of important diseases that our troops encountered in the Japan-Okinawa-Korea area.⁵⁸ One of



Fig. 8. Technician working with *Schistosoma*-infected snails in the Philippines.

them was Japanese B encephalitis, a severe outbreak of which occurred among the natives on Okinawa in the summer of 1945.⁷⁰ Incidentally in 1949 a number of cases occurred among U. S. troops in Korea.^{24,29} The disease, however, is also known to occur on Formosa, China, the Philippine Islands and Guam. Therefore, the nomenclature "Japanese B encephalitis" is perhaps slightly misleading.

It is known to be caused by a neurotropic virus and in the Okinawa epidemic seemed to be most prevalent in children.¹⁶ The total morbidity rate was 28.6%. In Japan the epidemics have had a greater mortality.⁶² This point is of considerable importance for up until recently it has been generally believed that morbidity increased with age. The Okinawa outbreak of 1945 did not conform with this principle. Of late this seems to be more and more true of Japanese epidemics indicating that the greater part of Japan's adult population has become immune by one means or another while the American personnel stationed there occupy the precarious position of a relatively non-immune population in the midst of a relative immune population.

The main vector of this disease is a mosquito, *Culex tritaeniorhynchus*. *Culex pipiens* is now accepted as another vector of importance.

Various mammals including horses, cows and goats as well as certain birds serve as reservoirs. This is borne out by the positive finding of neutralizing antibodies in many such animals that were tested.

There have been three types of tests used in the laboratory diagnosis of Japanese B encephalitis: a hemagglutination test, a neutralization test and a comple-

ment fixation test.^{17,56} The first mentioned test is one suggested by Sabin and has yielded excellent results. According to Tigertt, et al.,⁷⁰ and ourselves, complement fixation antibodies are of shorter duration than are neutralizing antibodies, though there is a small percentage of patients in whom complement fixing antibodies do persist for a number of seasons in titers sufficiently high to be detectable by the complement fixation test.

There is a high percentage of individuals inhabiting endemic areas who possess neutralizing antibodies⁴² but who are nevertheless asymptomatic. It has been assumed that this is due at least in part to the many "inapparent" infections that exist.^{8,10}

Patients with detectable titers of complement fixing antibodies are usually presumed to have recent infections though other factors such as mild re-infections and variations in laboratory technique may account for some of the noted variations.

Various vaccines^{2,19} have been developed though their value has not at the time of this writing been definitely established.⁵⁷ They can best be tested only during epidemics. Unfortunately the major Okinawa epidemic of 1945 did not afford us the valuable information that it might have since the vaccine had been administered too late.

Epidemic Typhus Fever

Although the disease occurred not infrequently among the civilian populace of Japan in all of World War II there was a total of 64 cases in American military personnel.

Epidemic typhus fever is caused by *Rickettsia prowazeki*, a small pleomorphic, obligate, intracellular parasite. It is transmitted by the human body louse, *Pediculus humanus corporis*, and the head louse *Pediculus humanus capitis*. It is not known whether any animal reservoirs are involved nor is it definitely known whether or not man serves as a natural reservoir. It is primarily, because of the habits of its vector, a disease of cold weather.

The best prophylaxis was the de-lousing of individuals, clothing, etc., with DDT.²⁰ All Americans were vaccinated.

The problem arose in Japan as to whether we were confronted with endemic or epidemic typhus because of the low

mortality and the close similarity of the symptoms. Here the complement fixation test, hitherto unavailable before the war, showed that the disease was epidemic or louse born typhus. A series of 30 paired specimens from cases of typhus occurring in 1946 in Japan gave identical results using rickettsial antigens of the two types of typhus by the Typhus Commission in Tokyo and our laboratory in Manila.

The epidemic typhus vaccine proved to be very efficacious given every three months in hyperendemic areas.^{14,15} Typhus was a real problem both in Japan and Korea under the extreme crowded conditions during and following the war. It was reported in Seoul, Korea, at one of their best hospitals each year, before the typhus vaccine was used, one-half of the staff of doctors and nurses died with the disease. It was very difficult to establish the manufacture of the vaccine for the civilians because of lack of the proper facility after the war in Korea especially.

Leprosy

Leprosy was a problem of the native population in New Guinea, the Philippine Islands, Okinawa, Japan and Korea.⁵³ No cases occurred in American troops to my knowledge. As it was very often seen to occur in the children of leprosy parents it appeared to render support to the generally accepted theory that leprosy occurs only after an individual has been in prolonged, close contact with infected individuals. Attempts to transmit the disease artificially from humans to animals by us were unsuccessful.

When Japan conquered the Philippine Islands the leper colony at Culion was not maintained, its inhabitants having been allowed to disperse throughout the various islands. It was quite a problem at the end of the war to re-gather the lepers. After much discussion among the health authorities it was decided to re-establish the colony at a point near Manila in order to have a medical service and further research studies more readily available. I personally visited this newly instituted colony ten or fifteen miles from Manila and found the doctors in charge of the colony and hospital to be well-trained, experienced and interested in all phases of the problem of leprosy. They were conducting the colony in a very commendable manner.

A recent trend of thought is somewhat along the lines of Dr. Gorgas of Panama Canal fame who believed that leprosy is not the highly infectious affliction it has traditionally been considered to be and that consequently isolation of patients can be adequately carried out in the home provided that proper isolation can be observed.

Many drugs had been tried as cures with very little success. One group of drugs, the "sulfones," did show promise. An example of such a drug is "promin."

Cholera

Cholera is a disease that was and still is one of the greater problems in the Far East. Epidemics of it were accepted as commonplace occurrences in Japan, China, and India. Since the war the control of cholera in Japan has been very good. The author recalls seeing a severe outbreak of cholera on some vessels returning Japanese prisoners. It was no problem to the American troops as they had been vaccinated and observed careful sanitary protective measures. The treatment of certain symptoms was important especially the dehydrating effect of the disease on its victim as well as secondary complications.

Smallpox

Smallpox has long been considered "a closed case" in this country as a result of our almost universal childhood vaccination. Nevertheless a number of cases in American troops have been reported in the Far East, apparently, despite vaccination.⁷³ Such breakthroughs have occurred in Korea. When these cases have occurred the disease appeared in all its classical fury, so to speak, resulting in some gravely severe cases. Nevertheless, it must be stressed that vaccination, our only weapon, gives almost complete though not always lasting protection provided that the vaccine has not been permitted to deteriorate and is administered properly under adequate supervision.⁵¹

Summary

We now come to the conclusion of our survey of tropical diseases of the Southwest Pacific area that were of military interest. Limitations of time and space have precluded our treating the subject in the full detail that might be warranted and that is already available in the standard



Fig. 9. Smallpox in Korea. A highly virulent type of smallpox was present among Koreans.

textbooks on tropical medicine. Rather, the author has endeavored to present certain aspects of these disease problems in the light of personal observations, impressions and recollections.

If our experiences of the last decade have taught us anything it has been the great importance of tropical medicine even in this day and age of wonder drugs and other miraculous chemotherapeutic agents. It is to be hoped that future research will bring us even closer to the goal of controlling and eventually eradicating these diseases.

I wish to take this opportunity to express appreciation to all medical officers, allied scientists, and technicians who assisted in making these observations, and furnished additional information for this presentation. The author also expresses gratitude to Bernard M. Wagner, 1st Lt., MC, and Martin Roth, M. A. for their assistance in the preparation of the manuscript.

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Management of Severe Allergic Bronchial Asthma

MAURICE KAUFMANN, M. D.

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Hyde Salter many years ago said that "Asthma is doubly capricious, the disease in general is capricious and each case is capricious in itself." This aphorism is still true.

There is no attempt in this discussion to classify the various types of allergic bronchial asthma or go into the pathologic physiology. The intent of this presentation is to include every proven remedy and procedure that one can command for the relief of this vicious and puzzling disease.

Preventive Measures (1)

Children of allergic parents who show a tendency for the allergic diathesis should be shielded from excessive allergenic exposure. Undue exposure to animals, feathers, (pillows and comforters), orris root and rice powder (in cosmetics), excessive quantities of house dust and large amounts of pollens should be avoided. During infancy and childhood, new foods should be added singly, at infrequent intervals, and in small portions. The occurrence of any allergic manifestation should be noted and recorded for future reference.

In general, a prompt and thorough allergic investigation should be carried out if atopic eczema, frequent "bronchitis" or croup, hay fever, rhinitis or wheezing occur. Skin tests, direct or indirect, should be comprehensive and should be followed by the elimination of the offending allergens when and wherever possible. Hyposensitization, when indicated, should be diligently pursued. It is easier to prevent asthma than to cure it. Allergic individuals, or children of allergic parents, should avoid the so-called "dusty" or allergenic occupations, such as being a farmer, baker, furrier, grain mill worker, domestic and beautician.

Specific Measures

Once an individual becomes clinically asthmatic he has the potential of always being susceptible to asthmatic attacks. Therefore, the first and best "treatment" is avoidance of the etiologic allergens,

whether it be an inhalant, ingestant, injectant, or contactant. Complete elimination leads to complete relief of symptoms, i. e., "cure" or arrest of the disease from a clinical point of view. From the immunologic standpoint, of course, "cure" is rare because recurrences usually follow re-exposure to the antigens.

The second specific measure is hypsensitization (desensitization). This consists of subcutaneous injections of increasing amounts and strengths of an extract made from important allergens which ordinarily cannot be avoided, e. g., house and occupational dusts, pollens, molds, and bacteria. The results are usually good.

Symptomatic Management

Generally speaking, it is well to remember that in treatment, no one measure is usually sufficient in itself and that there is no one regimen that alleviates each and every case of asthma. The management of severe allergic asthma usually requires considerable thought and ingenuity on the part of the physician, even then, failure still may result.

1. REASSURANCE. During any asthmatic attack or during status asthmaticus, one of the most important single measures is reassuring the patient. The value of this cannot be overemphasized. The patient in an acute attack of asthma feels he is smothering to death. The physician represents succor and relief and he should fulfill that role.

2. SUPPORTIVE THERAPY. Remember that the patient with asthma is not only anoxic but is probably dehydrated and perhaps acidotic and hypoglycemic. Segal (2) states that this situation demands immediate correction. Ordinarily, one can begin an intravenous infusion with normal saline or five per cent glucose in saline at the rate of 30 drops per minute. If the CO₂ combining power is found to be low, Hartman's (1/6 molar racemic lactate) solution can later be added until the acid-base balance is restored. Depending upon the cardiac condition it may be preferable to give only five per cent glucose in distilled water. If there is an associated cor pulmonale, 2 cc. of one of the mercurial diuretics may be required. Aminophyllin

(theophyllin ethylene-diamine), in varying doses may be added to the intravenous infusion. Theophyllin has been demonstrated to cause relaxation of bronchial spasm, lower intravenous pressure, and to generally stimulate the central nervous system. Aminophyllin also exerts appreciable antihistamine effect.

3. **PSYCHOTHERAPY.** This topic requires more than passing comment. The relationship of psychiatry to allergy continues to stimulate considerable interest, argument and thought. Emotional difficulties occur in many patients with asthma, just as they do in patients with any illness. Specific emotional factors and non-specific factors, such as fatigue or hormonal imbalance, precipitate, aggravate, or contribute to attacks of allergic asthma. These factors appear largely as contributing or ameliorating influences which disturb the delicate allergenic threshold. Whenever the psychogenic factor is recognized as being a major cause of allergic disorders, therapy should be directed toward its relief.

4. **INFECTIONS.** Foci of infection must be sought out and removed as soon as reasonably possible. Primary bacterial infections or secondary respiratory infections may be the trigger mechanism in initiating an attack of bronchial asthma. Every effort should be made to prevent these where or whenever possible. Stock or autogenous vaccine may be of great value in those cases that have a tendency toward recurrent respiratory infections. Para-nasal sinus infection or disease must be eradicated if possible. Antibiotic and chemotherapy, locally or parenterally, should be used when indicated.

5. **DIET.** This should be nourishing and high in carbohydrates and vitamins. It should be free from any known specific or common food offender, condiments, gas producing food or beverage, and foods that are difficult to digest. In children, be relatively certain that the supplementary vitamins are not allergenic.

Drugs

1. **EPINEPHRINE** (Adrenalin) still is the drug par excellence in the treatment of most allergic conditions and it is generally agreed that epinephrine is the drug of choice in the treatment of the patient with an acute attack of bronchial asthma. This medicament has been employed in various modifications, concentrations and routes. It antagonizes vagus-induced bronchocon-

striction and decreases tissue swelling by constriction of the capillaries of the bronchial mucous membranes. Gay (3) feels it is preferable to use 0.3 to 0.5 cc. of 1:1000 solution subcutaneously, the amount depending upon age of patient, at 15 minute intervals repeated several times if necessary, rather than a single large injection. Epinephrine 1:500 in oil or gelatin has a longer duration of action and is valuable in selected cases. The use of the hypodermic needle for self-medication, which generally should be avoided, is too often encouraged. Habitual users of self-administered hypodermics of epinephrine become dependent upon this crutch which further contributes to the despair of the disease. The epinephrine-fast state is encountered most commonly in these patients. Aqueous solutions of 1:100 epinephrine by inhalation route has also been used successfully. Epinephrine should be used with caution in diabetes mellitus, hyperthyroidism, coronary disease, and left ventricular failure.

2. **EPHEDRINE.** This drug whose pharmacologic action is very similar to epinephrine has two advantages over the latter. Its action is more prolonged and it can be given by mouth. However, it has many side reactions, notably palpitation, headache, jitteriness, and insomnia. Its usefulness is enhanced when combined with antihistamines, aminophylline, and sedative preparations such as barbiturates. This is particularly applicable for the ambulatory, mild chronic asthmatic patient.

3. **AMINOPHYLLINE** (and related drugs). The value of aminophylline when used intravenously was mentioned above. The next most effective route is per rectum and it can be administered in the form of an enema or in suppositories of 0.3 to 0.6 gram dose at four, eight, twelve, or twenty-four hour intervals, depending upon the individual case. Oral tablets have possible advantage in selected cases such as an associated chronic emphysema.

4. **EXPECTORANTS. IODIDES.** These drugs have been employed in the treatment of asthma for hundreds of years. They tend to liquify and render the mucus less tenacious. Intolerance to it must be remembered and watched. Potassium iodide is ordinarily used in saturated solution orally, ten to fifteen drops three times daily usually after meals to prevent gastric distress. In status or acute refractory cases, one half to one gram of sodium iodide dissolved in 10 cc. of distilled water

may be given by vein daily. This can be incorporated with other intravenous fluids. Also of considerable value, if iodides cannot be tolerated for some reason, is ammonium chloride and potassium citrate given by mouth with generous quantities of water to help promote liquifaction of the mucilaginous secretions present in the bronchial tree.

IPECAC, particularly in children, has been recommended by Ratner (4) as a valuable adjunct in treatment. Ipecac acts by substituting effective retching in place of ineffective coughing. In the obstructive type of bronchial asthma the production of "tracheal vomiting" may eliminate considerable "glue" from the bronchial tree. It has been recommended worth a trial before attempting bronchoscopy in obstructive cases.

5. SEDATIVES. Every effort should be made to put the patient at complete mental and physical rest without depressing the respiratory center. Psychic trauma often is an important trigger mechanism in initiating an acute attack or intensifying a chronic intractable asthma. It is better to avoid heavy sedation as the incidence of obstructive asphyxia and pulmonary edema is highest in the deeply sedated patient. Therefore, only those agents which have a wide margin of safety should be used. For this purpose, chloral hydrate (1 to 2 Gm) or one of the barbiturates (15 to 30 mg) repeated several times daily may be helpful. Perhaps the best of these is sodium phenobarbital in doses of 0.1 to 0.2 gram given subcutaneously or with the intravenous infusion once or twice daily. Paraldehyde in 5 to 15 cc. dosage may prove an effective hypnotic.

Morphine is mentioned only to decry its use. It is dangerous and contraindicated in bronchial asthma. On the whole, morphine tends to depress the respiratory rate, diminish tidal volume, and decrease the minute volume of respiration, thus increasing the degree of hypoxia. It also decreases the cough reflex, prevents effective expectoration and thus may increase the tendency towards atelectasis. Mepерidine hydrochloride (Demerol) has a far wider range of safety than morphine and is a more efficacious drug in the treatment of the very sick asthmatic patient. It is extremely helpful in relieving an intractable or utterly useless cough. The usual dose is 50 to 100 mgm intramuscularly or 100 to 150 mgm orally at 8 to 12

hour intervals for 3 to 5 days, never longer. The temporary use of demerol combined with aminophyllin may serve as a substitute in the epinephrine refractory state until the response to epinephrine is restored.

Ether in oil, 3 ounces of each, given as a retention enema, has on occasion been very useful in gaining complete relaxation. This may be repeated several times during 24 hours for several doses, if necessary. A preparation for intramuscular use is also available commercially.

6. ANTIHISTAMINES. The property of these drugs, as a whole, is well known. However, they do have histaminolytic properties and when administered intravenously these agents may effectively block the action of freely circulating histamine. Furthermore, these agents may be of particular value in the following instances. First, when given orally for the relief of nasal obstruction. (Allergy is the dominant factor in the maintenance of chronic para-nasal sinus disease in the asthmatic patient.) Second, when given intravenously for the relief of bronchospasm in the ambulatory patient having an acute asthmatic paroxysm. Third, when given intravenously or intramuscularly to restore the delicate histamine-sympathin balance in the so-called epinephrine refractory state. And fourth, when given intramuscularly or subcutaneously for sedative effect in status asthmaticus.

7. OTHER DRUGS: Orthoxine, one of the newer ephedrine-like synthetic drugs, may produce fewer side reactions, has been well tolerated in 200 mgm doses at four hour intervals and has appeared to help some patients. Khellin, another new drug, has been reported as relieving bronchospasm. It is usually prescribed in 10 to 20 mg tablets three to four times daily. Isuprel hydrochloride is similar to other sympathomimetic drugs in action and has the advantage of sublingual usage.

Therapeutic Use of Gases and Aerosols

1. OXYGEN is mandatory in those cases with hypoxia and cyanosis associated with bronchial asthma. There are many ways oxygen can be administered but it is recommended that 95% oxygen administered with the O. E. M. mask is most advantageous. This provides accurately controlled air-oxygen mixtures. Rebreathing and carbon dioxide accumulations are totally eliminated. In addition, the face mask has an attached expiratory outlet that has

been metered for positive pressure in expiration up to 4 cm of water pressure. Other methods of oxygen administration which are satisfactory include the B. L. B. mask, tent, hood and nasal catheter.

2. **HELIUM-OXYGEN MIXTURES.** A mixture of 80% helium and 20% oxygen is 1/3 as heavy as air. Barach (5) has shown that with this mixture it is possible to compensate for approximately 50% constriction in the lumen of the tubal respiratory tract. This may be of inestimable value if a severe mechanical obstruction exist, such as inspissated mucus. The percentage of each gas can be controlled by a Y tube to the apparatus used. The helium-and-oxygen hood rebreathing apparatus is the most effective one for administering oxygen or the helium-oxygen mixture, with or without pressure.

A word about positive pressure therapy. This is indicated in the treatment of various types of pulmonary edema, bronchial asthma and obstructive respiratory disease. Physiologically, it opposes the hydrostatic pressure within the capillaries. Thus it acts as a tamponade, therapy reducing edema.

3. **AEROSOLIZATION.** (Nebulization, vaporization). Here the size of the particle delivered is most important in order to reach the selected area. Sizes of 0.6 to 2.0 micra are best. Abramson (6) and other investigators interested in aerosol therapy have employed the De Vilbiss No. 40 or Vaponephrin nebulizer. Vaponephrine (racemic epinephrine hydrochloride) and Isuprel hydrochloride 1:200 or a mixture of 0.5 cc. of each, are of particular value for the relaxation of bronchospasm. As little as approximately 0.05 to 0.10 cc. of one of these solutions, nebulized by 3 to 6 compressions of the hand bulb, may abort or relieve a mild bronchospastic episode. They may also be nebulized by continuous flow of oxygen or helium-oxygen mixture air pump. Other solutions and medications such as aqueous epinephrine 1:100, neosynephrine 1%, penicillin or streptomycin may be incorporated or substituted as indicated. Numerous other commercial preparations for aerosol use are readily available such as Aerolin and Norisidrine, to mention a few proprietary drugs.

Bronchial Evacuation

Judicious use of the bronchoscope for suctioning out the thick, tenacious, gelatinous mucus in the bronchial tree, that

cannot be displaced otherwise, may prove life saving. Bronchoscopic examination can also serve as a valuable diagnostic aid if there is some question as to the obstructing agent. Other practical purposes of the bronchoscope can be for endoscopic instillation of iodized oil preparations, penicillin and streptomycin. Its use is excellent for bronchial lavage and thereby may serve to prevent serious sequelae such as obstructive emphysema, segmental atelectasis and bronchiectasis. The medical approach to bronchial evacuation has been emphasized above.

Asthma Exercises

Physical exercises for the asthmatic patient have proven helpful and practical for those who will carry them out. The Asthma Research Council which was formed in England in 1927 points out that the first objective in treating the chronic asthmatic patient by exercise is to restore the lungs and chest cavities to their normal size and in those early cases in which the muscles of the chest have not yet assumed a new length which keeps the lungs over-distended, is to prevent this distention from occurring. Effective exercises are designed to teach the patient: first, to use the lower part of his chest as well as the upper part and second, to employ the diaphragm to a greater extent than has been his custom. It is essential that these exercises be carried out correctly.

Endocrine Therapy

Whenever indicated, estrogens and androgens may restore hormone imbalance which contributes to a lowered asthma threshold. Thyroid apparently is beneficial in some cases of asthma, especially in children. Finally, a spectacular new chapter has been added to the armamentarium for combating asthma and other allergic manifestations. The remarkable properties of the pituitary adrenocorticotrophic hormone (ACTH) and Cortisone with their effect on the antigen-antibody mechanism is still a subject receiving considerable study. Neither of these two preparations can be considered as a specific in producing a cure since there are relapses and recurrences following their use. The period of remissions are variable but fortunately courses of treatment can be repeated. When successfully employed, striking subjective and objective improvement appears within one to several days. Occasionally the hormone may

be employed in responsive patients, for the maintenance therapy for two to three months or even longer, depending upon the particular case and other factors. With our present state of knowledge concerning the use of these hormones in asthma, perhaps the greatest benefit is derived in status asthmaticus. Even here failures have been reported. The modus operandi of ACTH and Cortisone in asthma is not definitely known. The usual precautions should be taken when these hormones are used and necessary supplementary medication given.

In conclusion, severe allergic bronchial asthma is a very serious, distressing, and

difficult disease and its treatment merits a trial of every known worth while remedy.

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- (180 Market Street)

Special Article

The Governor Makes A Request

The Committee on Emergency Medical Service of the Kentucky State Medical Association has asked the Journal to print the following letter from Governor Lawrence W. Wetherby to Clark Bailey, M. D., President of the Association, and Dr. Bailey's reply.

Commonwealth of Kentucky

Executive Chamber

Frankfort

Lawrence W. Wetherby

Governor

January 7, 1952

Dr. W. Clark Bailey, President
Kentucky State Medical Association
Harlan, Kentucky

Dear Dr. Bailey:

From a study of conference reports and other related data on health services organization for civil defense, I am impressed by the showing of those states in which such preparation on the part of the medical profession has been made by the physicians themselves, working through their state and local organizations in cooperation with civil defense officials.

I have noted with gratification the work of your Committee on Emergency Medical Service which has organized and promoted courses on the medical aspects of atomic explosion for physicians in several Kentucky cities, and recommended formation of an emergency medical service committee by each county society. However, I note also that as of October 1, 1951, less than one-fourth of all county medical societies had reported appointment of such committees, and your state committee in its report mentioned "resistance within the profession" to more active civil defense preparation.

Since your Association was represented at the recent civil defense conference in Chicago, you no doubt have a report indicating the general agreement among the group panel participants on several points: Most mobile support will have to be provided from non-target areas; medical personnel should be organized into teams on an equitable basis between communities,

so that the total mobile support which the State can furnish may be known; physicians who are not members of hospital staffs or medical societies must be included in plans, as their services will be needed; hospital authorities must be urged to plan emergency expansion, and the professional staff must take an active part in such plans. I do not doubt that you will also agree much remains to be done before plans and organization for mass care of casualties in Kentucky may be regarded as satisfactory. Kentucky physicians are busy, and many, together with a large proportion of our people, probably feel that the danger of attack on our civil population is remote. Good civil defense organization can be used in non-military disasters as well, and is in itself a strong deterrent to aggression.

I should like to request that the task of organization of the medical profession of Kentucky for civil defense, on a state-wide basis, be assumed by the Kentucky State Medical Association. In this connection, the State Director of Civil Defense and his staff will be glad to assist in every possible way.

With kindest regards and all good wishes, I am

Sincerely yours,

LAWRENCE W. WETHERBY, Governor

January 21, 1952

Hon. Lawrence W. Wetherby, Governor
Commonwealth of Kentucky
Executive Chamber
Frankfort, Kentucky

Dear Governor Wetherby:

Your letter of the 7th requesting that the task of the organization of the medical profession of Kentucky for civil defense, on a state-wide basis, be assumed by the Kentucky State Medical Association was received. The Kentucky State Medical Association accepts this request and will use every effort at its command to implement its action.

Dr. G. Y. Graves, Bowling Green, Ky., is Chairman of the Committee on Emergency Medical Service. Your letter to me was sent to him with the suggestion that

his committee take immediate action in regard to this request. Also, your request has been placed upon the agenda for the next meeting of the Council of the Kentucky State Medical Association which meets in Lexington next Thursday, the 24th.

We appreciate your confidence in placing this responsibility upon us and assure you that we shall make every effort to effectively organize and train the medical personnel to heartily cooperate with

the Director of Civil Defense in our state program.

As President of the Kentucky State Medical Association, I pledge to you, not only my own personal support, but that of all the other officers of the Association.

With kindest regards, I am

Sincerely yours,

CLARK BAILEY, M. D.

The JOURNAL *of the* Kentucky State Medical Association

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THE FUNCTION OF THE ADVISORY COMMITTEE TO SELECTIVE SERVICE

Many members of the Kentucky State Medical Association have a misunderstanding as to who selects the names of Kentucky physicians called for service in the armed forces and who initiates the call. This is a matter of great concern to the Kentucky Advisory Committee to Selective Service.

It will be remembered that in 1950, Congress passed the so-called Doctor Draft Act, which is Public Law 779. Under this Act the National Advisory Committee was created with its chief purpose being to keep the proper balance between needs for professional services in armed forces and the public. The same act stipulated that state committees be formed, with the national committee naming the committee chairmen and two other members for each state.

The State Committee Chairman was then authorized to proceed with perfecting the organization of his committee, which would include members of the medical, dental and veterinary professions. It was determined the Committee as a whole would set policy but that each profession would deal with its problems individually.

At first the Advisory Committee was asked to make recommendations only to Selective Service. Later the Committee was asked to pass on the availability of

members of the Army Reserve who had received a notice to report to active duty. A short time later, the Air Force and Naval Reserve calls were officially included in the Committee's work.

At no time in the past or at present has the Kentucky Advisory Committee had anything whatever to do with the call of any one to active duty by either Selective Service or any reserve components of the Armed Forces. The determination as to who shall receive a call is made without the knowledge, advice or counsel of the Kentucky committee.

After it had been decided who is to be called, the individual names are submitted to the committee to investigate, consider and make recommendations as to the availability for service. At this writing all recommendations of the Kentucky Committee have been accepted by both Selective Service and the Armed Forces Reserve components.

While all obviously cannot be pleased, the committee has established a reputation for fairness in all groups it reviews. It always welcomes information that may be presented to it; however, it discourages activity of pressure groups or political interference. If such is brought to bear, the Committee feels that it should withdraw consideration of the individual and let matters take their course.

SCHOLARSHIP FUND NOW PROVIDING MAXIMUM ASSISTANCE

Kentucky is doing something on her own to give better medical care for the 2,000,000-odd dwellers in her rural areas. The program of the Rural Kentucky Medical Scholarship Fund is beginning to bear solid fruit.

In six years of the Fund's service, 61 new doctors helped to an education by its loans are either in training pledged for rural practice, or about to move into it from their completed internships, or already active in eleven widely scattered counties. The gaps among the honored and indispensable general practitioners of rural Kentucky—gaps created by super-

annuation or death of so many—are being filled.

Kentucky's medical profession has reason to look with satisfaction at this record of progress toward filling a great need which goes without saying. The fund was sponsored by the State Medical Association, in cooperation with the University of Louisville. It is administered by a board of trustees representing every interest in the state, and first and last imbued with a feeling for the state and her problems.

It is, thus, a Kentucky program for Kentucky. Of the 61 young men who have

been helped, 56 are Kentuckians. Two are Tennesseans, one is from Indiana (almost within sight of this state) and one each from California and New York. The latter two, as students of the University of Louisville, had decided to cast their lot with us, a decision which we of course deem a natural one.

In view of the purposes of the fund, to induce settlement in rural "under-doctored" areas, it is noteworthy that of the 56 Kentuckians, 48 are from small cities and farms. They have rural backgrounds. They have a sense of belonging—and, the trustees affirm, a certain sense of dedication. There is much evidence to show that for the large proportion of the young men, the commitment is not a quid pro quo for a loan, to be swiftly discharged under the terms of the loan and then to be set aside for city practice and specialization. For most if not all of them, a life's vocation has been accepted.

Nine are already in active practice. Two others who had entered rural practice went into the medical service of the armed forces, one to the Army, the other the Navy. At least one of these will resume his practice when released, if not both.

Six others, finishing their year as internes, will be ready to assume rural practice this summer. Ten rural scholarship students will be graduated in June. Ten are completing each the junior and sophomore years of study, twelve will complete their freshmen year.

There is no record of a more fruitful and promising venture among all the undertakings to solve the problem of the "disappearing country doctor." Here is truly indigenous effort, coming of the people and their professional representatives. The fund is the product of public subscription. By gifts and a small increment from careful short-term investment, the sum totalled \$153,351.09. Of this, loans have been granted in a total of \$154,023, and practically all of the balance committed for completion of the education of borrowers who have just started.

But this does not mean the fund's exhaustion. It means that the leaven has rather just begun to work. For soon the first of the new doctors will be repaying their loans, and the revolving fund will be taking on a balance and rhythm. Up to now the record has been one of making a start. From now on, it is hoped, there will be a steady and methodical replenishment, each year a new wave of the dedicated.

(Signed) TARLETON COLLIER

EDITOR'S NOTE: The above Guest Editorial was written by Mr. Tarleton Collier, a senior member of the editorial staff of the Louisville Courier-Journal. Mr. Collier is a member of the Board of Trustees of the Rural Kentucky Medical Scholarship Fund and has made a major contribution to the successful operations of the Fund from its beginning.

THE PHYSICIAN-TO-BE GETS LONG-DELAYED ATTENTION

One of a number of indications that Organized Medicine is becoming of age is the attitude it is taking toward the physician-to-be. The thoughtless and tragic omission of not indoctrinating medical students in the ethical standards with respect to both internal and external professional relationship; and of failing to acquaint and interest them in the vehicle of medical organizations to accomplish these objectives is being corrected.

The officers of your State Medical Association have become increasingly conscious of this need. Several years ago a student K.S.M.A. was activated with the annual membership fee being one dollar

which includes an annual subscription to the Journal of the K.S.M.A. The Association welcomes these doctors-of-the-future. It looks to them for a better association in the years ahead.

Officials of the University of Louisville, have cooperated in a fine way in giving representatives of the Association a period each fall with each class to discuss organizational matters. For the past two years, all Classes at the Medical School have been invited to attend the Annual Meeting. The students are urged to sit in on the scientific meeting, to visit the scientific and technical exhibits and to see the scientific movies.

The American Medical Association authorized the formation of a Student A.M.A., which was organized early in 1951. Students at the University of Louisville have one of the charter chapters. There was provided a National Meeting of the Student A.M.A. House of Delegates. The Student organization was asked to send two students to the A.M.A. House of Delegates for each meeting. Approximately sixty per cent of the Medical Students of the country have joined the Student A.M.A.

The latest and most effective effort on the part of the A.M.A. to demonstrate its desire to be of service to the student organization is the issuance of a new national medical publication entitled "The Journal of the Student A.M.A.", which made its appearance in January of this year. This colorful and attractively printed magazine breaks with traditional stolidity and unimaginative pattern that has characterized medical journalism down through the years.

The new journal is a well balanced publication. It carries appropriately written scientific matter, by both physicians and students. Its several departments meet

the various needs of the student. From month to month the news letter brings worthy capsule information; the Washington Wire answers reader questions on legislation proceedings and developments. Brief, intimate pictures of the authors of each issue are printed along with the social and economic aspects of medicine.

In a commentary on the new A.M.A. effort, the astute editor of the New England Medical Journal said, "One danger inherent in an organization so developed will of course be assiduously avoided—that of excessive paternalism. No generation has done so well in its conduct of the world's affairs that it dare recommend its own methods to its successors; all it can do is to point to its achievements and warn against its failures.

"The generation in action can only implore the one in training to guard the freedom of the future and perpetuate as few as may be of the errors of the past. It is a charge on today's leaders that the younger men who accept their guidance shall be left free to develop their own opinions and shall be protected against the risk of being suckled in any creeds of unrevised traditionalism."

ORGANIZATION SECTION



**Paul D. Crimm, M. D., President,
Indiana State Medical Assn.,
Indianapolis, Ind.
1952-53**

Well Balanced Scientific Program To Include Dr. Crimm

"The scientific program for our Annual Meeting this year will feature outstanding guest and state speakers and we think it is well balanced," Clark Bailey, M. D., Harlan, Chairman of the Committee on Scientific Assembly, said in announcing that the program is just about completed.

"Typical of the calibre of men we have is Paul D. Crimm, M. D., widely known chest specialist and for the past 22 years director and thoracic surgeon at the Boehne Tuberculosis Hospital at Evansville, Indiana. Dr. Crimm is a member of the American College of Chest Physicians, past director of the National Tuberculosis Association, a member of the American Trudeau Society and a member of the American Association of Thoracic Surgery," Dr. Bailey stated.

A graduate of Western Reserve Medical School, Dr. Crimm is a veteran of World War I, a past president of the Vanderburg County Medical Society, President-Elect of the Indiana State Medical Association, and is associated with many civic activities. "Dr. Crimm will

be our first guest speaker at the first scientific session, Tuesday morning, October 7," Dr. Bailey announced.

In discussing the program as a whole, the Chairman said that while all of the men to appear on the scientific program were of recognized top flight talent, each speaker has been informed that his audience will be made up largely of general practitioners and has been asked to direct his remarks primarily to them.

The 1952 scientific program will be composed of six full half day sessions, starting on Tuesday morning and ending Thursday afternoon. The Oration in Medicine will be given Tuesday morning by Joseph M. Bush, M. D., Mt. Sterling, and the Oration in Surgery by Gaithel Simpson, M. D., Greenville.

Rural Health Session Attracts 204, Called "Very Successful"

The First Kentucky Rural Health Conference, held in Louisville, May 7 and 8, for which 204 registered, 46 being physicians, was regarded as being eminently successful, according to Walter L. O'Nan, M. D., Henderson, Chairman of the Kentucky Rural Health Council.

Five nationally known out of state speakers were on the program along with nine from Kentucky—most of whom were members of one of the thirteen organizations which hold membership in the Council.

One of the high points of the Conference was the address made by Mrs. Charles E. Sewell, Otterbein, Indiana, and one of the co-founders of the Rural Health Movement, delivered at the dinner meeting the evening of the seventh. K.S.M.A., Farm Bureau and other officials of the Council felt that Mrs. Sewell made a most beneficial and outstanding talk.

J. E. Stanford, Executive Secretary of the Kentucky Farm Bureau Federation, presided at the banquet. F. S. Crockett, M. D., Lafayette, Indiana, Chairman of the Council on Rural Health of the American Medical Association, spoke along with Raymond Dixon, Secretary of the Rural Kentucky Medical Scholarship Fund, who gave a report of the Fund.

Aubry Gates, Little Rock, Arkansas, Field Director of the Council on Rural Health of the A.M.A., was one of the stand-outs on the opening program. Mr. Gates explained the difference between medical care and community

health and placed responsibility for each. Allen O. Grubbel, D. D. S., Chicago, Secretary of the Council on Dental Health of the American Dental Association, was also a feature.

Guest speakers at the morning session included the new Dean of the College of Agriculture, University of Kentucky, Dr. Frank Welch; and Sewell Milliken, Director of the Division of Public Health Education, Ohio State Department of Health, and a widely recognized authority on Rural Health.

Other speakers were: Clark Bailey, M. D., Harlan, President, Kentucky State Medical Association; James Armstrong, Henderson; Miss Myrtle Weldon, State Leader, Home Demonstration Agents, Extension Division, University of Kentucky; Mrs. Tom Dulin, Chairman Health Committee, Kentucky Farm Bureau Federation; D. G. Miller, Jr., M. D., Morgantown, Member, A.M.A. Council on Rural Health; R. Haynes Barr, M. D., Owensboro, President-Elect, Kentucky State Medical Association.

While attendance at the conference was felt highly satisfactory, the impact of the meeting was felt through the media of television, radio, and newspapers before untold numbers. Both Louisville T-V stations featured it and WAVE used a half hour 5-man panel of conference speakers. Six of the conference speakers appeared on five different radio programs and press coverage was very good, Dr. O'Nan said.

Among the out of state guests at the conference was Mrs. Arline Hibbard, Secretary of the Council on Rural Health of the A.M.A. and Hartley Page, Columbus, Ohio, who has done outstanding work as secretary of the Committee on Rural Health of the Ohio State Medical Association.

Walter L. O'Nan, M. D., Chairman, K.S.M.A. Committee on Rural Health, presided at the afternoon session and Clyde C. Sparks, M. D., Chairman, Council of the Kentucky State Medical Association, presided at the morning session.

Delegates to Get Committee Reports Before House Meets

Reports of the Officers, Committee Chairman and the Council will be mailed to the members of the 1952 House of Delegates to the Annual Meeting of the Association approximately two weeks before the first meeting of the House of Delegates the evening of October 6, in the Columbia Auditorium in Louisville.

This action was taken by the Council at its May 8 meeting in Louisville after receiving recommendations from the Committee on Ar-

rangements and the Executive Committee. By sending the reports out before the annual session, the Delegates will have more time to become informed, it was held.

The Council also voted to ask the Nominating Committee to hold a meeting immediately at the close of the first session of the House of Delegates, Monday evening, October 6, at a previously advertised place, so that all who would like to make suggestions would have the opportunity. The Council, in addition, asked the Nominating Committee to make its report at the Second Scientific Session, which will start at 2 p. m., Tuesday, October 7. Election of officers for the ensuing year will be held at the second session of the House, Wednesday evening, October 8.

In order to process and prepare for mailing the great volume of material that makes up the reports of all of the officers, agencies and committees of the Association, August 15 was set as the date these reports should be submitted to the Headquarters Office. Having this rule, however, does not preclude the officer or committee from making a supplemental report at the time of the first meeting of the House, the Council said.

Civil-Defense to Be Emphasized At Annual Session, Oct. 7, 8, & 9

The various aspects of Civil-Defense, as related to the Medical Profession, will be one of the features of the Annual Meeting October 7, 8 and 9, Clark Bailey, M. D., Harlan, President of the Association has stated.

"Governor Lawrence W. Wetherby has asked the Medical Association to set up an organization that will be ready on a moment's notice to go into action in case of any disaster requiring medical care. The Committee on Emergency Medical Care has held several meetings and is doing an excellent work in this direction.

"At our annual meeting special emphasis will be given to the civil-defense for two purposes. The first will be at the Public Meeting, Tuesday night, October 7, when a nationally recognized authority will be presented, who will direct his talk toward making the public more conscious of its responsibility. The second phase will be a symposium on Civil Defense that will be staged at the third scientific session, and which will deal with treating atomic casualties," Dr. Bailey said. The Committee on Scientific Exhibits plans to present a special exhibit on this subject.

First Academy Session Attracts 100 On April 30 in Louisville

More than 100 members of the Kentucky Chapter of the American Academy of General Practice attended its first annual day-long scientific session held April 30 at the Kentucky Hotel, Richard Slucher, M. D., Buechel, President, has announced.

A feature of the meeting was the addresses given by the National President, R. B. Robins, M. D., Camden, Arkansas, and the Executive Secretary, Mac F. Cahal of Kansas City, Missouri. Wives of the members and members of the Senior Class of the University of Louisville School of Medicine, were invited to the luncheon.

K.S.M.A. members on the program were Robert Lich, M. D., and Alex Steigman, M. D., both of Louisville. Other guest speakers included Joseph G. Crotty, M. D., University of Cincinnati; Bernard Weinstein, M. D., Tulane University; and Phil Thorek, M. D., University of Illinois.

Academy officials expressed themselves as being very gratified at the interest and response shown at this meeting.

Scientific Exhibitors Asked to Apply For Space Before Aug. 1

Members of the Association who would like to have a scientific exhibit at the Annual Meeting in the Columbia Auditorium in Louisville, October 7, 8 and 9, should apply to Committee on Scientific Exhibits Chairman, Everett L. Pirkey, M. D., 323 East Chestnut Street, Louisville, for an application and return it to him before August 1.

All guest and State Essayists on the Scientific Program, will be given an opportunity to have a scientific exhibit in connection with their presentation, Dr. Pirkey said. He pointed out that he had already received a number of applications for space in the somewhat limited quarters where the exhibits will be set up.

Pediatrics PG Course Begins June 5

A Pediatric Postgraduate Course, sponsored by the Kentucky State Medical Association, will be held at the Children's Hospital, Louisville, beginning Thursday, June 5, 1952, and ending July 24, 1952. The meetings will be from 9 A. M. to 12 Noon on the eight consecutive Thursdays.

An invitation is extended to all physicians to attend this course.

Inquiries should be sent to W. W. Nicholson, M. D., 1974 Douglass Boulevard, Louisville 5, Kentucky.

The program for the last four weeks of the course follows:

Thursday, July 3

9-10 Pediatric Urology...Robert Lich, M. D.
10-11 Staff Conference

Leonard T. Davidson, M. D.

Discussion by...Martin Z. Kaplan, M. D.

11-12 Nephritis and Nephrosis

Joseph A. Little, M. D.

Thursday, July 10

9-10 Fluid and Electrolytes in the Treatment of Diarrhea...William A. Brodsky, M. D.
10-11 Staff Conference

Leonard T. Davidson, M. D.

Discussion by...Walter A. Kirchner, M. D.

11-12 Juvenile Diabetes

William A. Brodsky, M. D.

Thursday, July 17

9-10 Tuberculosis and Histoplasmosis
Leonard T. Davidson, M. D.
10-11 Staff Conference

Leonard T. Davidson, M. D.

Discussion by...John B. Larson, M. D.

11-12 Convulsive Disorders in Childhood

Ephraim Roseman, M. D.

Thursday, July 24

9-10 Newer Antibiotics in Infectious Disease...Alex J. Steigman, M. D.
10-11 Staff Conference

Leonard T. Davidson, M. D.

Discussion by...Margaret Limper, M. D.

11-12 X-Ray Conference

Donald K. Bailey, M. D.

Kentuckians to Take Part in Scientific Program at Annual AMA Meeting

Ten K.S.M.A. members are scheduled to participate in the Scientific Program of the annual A.M.A. Meeting in Chicago, June 9-13.

Everett L. Pirkey, Lawrence A. Davis, and Lawrence A. Pilla, Louisville, are to present a paper on "Preoperative and Postoperative Cholangiography"; the discussion will be led by James C. Drye, Louisville.

Other members scheduled to discuss scientific papers to be presented at various sections of the June A.M.A. Meeting are: Willard L. Cooper, Lexington; R. Glen Spurling, Ludwig Sigerberg, Spafford Ackerly, Ephraim Roseman, and Z. S. Gierlach, all of Louisville.

Four scientific exhibits are being sponsored by Kentuckians, according to the program. They are:

Section on General Practice—"Rural General Practice Without a Hospital"—D. G. Miller, Jr., University of Louisville School of Medicine, Morgantown and Louisville.

Section on Nervous and Mental Diseases—"Social Group Work—A New Service to the Emotionally Ill Patient on Private General Hospital Care"—Cuthbert C. Gifford, Murray Kinsman, Arden C. Hardgrove, Spafford Ackery, and E. E. Landis, Norton Memorial Infirmary and University of Louisville School of Medicine, Louisville, Kentucky.

Section on Radiology—"Preoperative and Postoperative Cholangiography"—Everett L. Pirkey, Lawrence A. Davis and Lawrence A. Pilla, University of Louisville School of Medicine, Louisville, Kentucky.

Section on Miscellaneous Exhibits—"Kentucky State Medical Historical Exhibit—Dr. Ephraim McDowell Memorial"—Charles A. Vance, Mrs. Walker Owens, and Mrs. D. L. Henderson, Louisville, Kentucky.

Dentists Appoint Liaison Groups

The Kentucky State Dental Association has named a committee on Rural Health to represent it on the State Rural Health Council and a Medical Liaison Committee, according to the Secretary of the Association, Bing Coxwell, D. M. D., Louisville.

Appointed on the Rural Health Committee were H. Collins Randall, D. D. S., Columbia; Woodfin Hutson, D. D. S., Murray; and John I. McDowell, D. D. S., Maysville. The Chairman of the Liaison Committee is A. P. Williams, D. D. S., who will serve with Frank Jordan, D. D. S., and Sherman Vogt, D. D. S., all of Louisville.

U. S. Supreme Court Rules in Favor Of Oregon Medical Assn.

The Supreme Court of the United States, by a vote of seven to one, dismissed the appeal of the government against the Oregon State Medical Society, eight county medical societies and the Oregon Physicians Service (Blue Shield) in the government's suit filed by the Department of Justice alleging violation of the Sherman Act, according to the Bulletin of the A.M.A. Washington office.

Mr. Justice Black was the lone dissenter. Mr. Justice Clark did not participate in the decision, as was thought because he was the Attorney General at the time the litigation was initiated. Mr. Justice Jackson wrote the opinion, the Bulletin said.

There was much interest in this case, which had received an adverse ruling in the U. S. District Court, and had been appealed directly to the Supreme Court. Any member desiring to read the opinion should write the Headquarters Office and the effort by it to get the opinion will be made at once.

KSAP Holds Annual Meeting

The third annual meeting of the Kentucky Society for the Advancement of Pediatrics was held Friday, April 18, 1952, at the Pendennis Club, Louisville, from 4:00 p. m. through 9:30 p. m.

Featured speakers were: Aims McGuinness, M. D., University of Pennsylvania, and A. A. Weech, M. D., University of Cincinnati.

Directory of Committee Chairmen, County Officers, Deleted

Beginning with this issue the Journal will cease to carry the directory of committee chairmen of the State Association and the directory of county society presidents and secretaries.

The directory of officers and councilors has been moved from near the front of the Journal to the page that bears the masthead and which precedes the editorial page.

Acting on the old newspaper axiom that "every word that gets into print costs money" the Editorial Advisory Committee authorized the changes as a means of reducing publication costs. It was pointed out that it had been costing several hundred dollars each year to carry this information.

The Committee did provide, however, that at least once each year the names of all county medical society presidents and secretaries and all committee chairmen would be printed in the Journal and prominently displayed.

Nurse Fund Set By Logan Staff

The Medical Staff of the Logan County Hospital has established a \$400 scholarship which will provide funds for a full professional education in nursing at an accredited school for one county high school graduate, according to Mr. Harold Pilon, Hospital Administrator.

The scholarship will be awarded to a county girl on the basis of the following points: 1. Scholastic standing; 2. Financial status; 3. Personality; 4. Appearance. 5. Physical examination; and 6. Aptitude. Information and application forms are being made available to all high schools in Logan County.

Council Releases P-R Consultants

Because of the need of living within its budget, the Council, at the May 8 meeting, voted after considering the matter for several months, to discontinue the services of the Public Relations consultants, effective June 1, 1952.

The firm of Mullican and Company, which was employed last summer, was told that the Association appreciated the services it had rendered, and that it regretted the necessity of terminating their employment.

First District Meets At Hickman

Forty physicians attended a meeting of the First Councilor District Tuesday, May 6, 1952, at the Methodist Church in Hickman, with the Fulton County Medical Society as host. J. Vernon Pace, M. D., Councilor, has announced.

W. W. Taylor, M. D., and Harwell Wilson, M. D., Department of Medicine, University of Tennessee, Memphis, brought the program.

Army Announces Intern Program

Five Kentuckians were among 146 senior medical students appointed for the Military Intern Program of the Army Medical Service, according to Major George E. Armstrong, Army Surgeon General.

The 1952 program, starting in July, provides for the commissioning of medical students, upon graduation, as first lieutenants in the Medical Corps Reserve to serve their internships in Army hospitals.

The Army is calling up 232 physicians from its reserves for duty beginning in July. Dentists called at the same time will come from Priority II as all Priority I dentists available have been called. Also Selective Service will begin re-examining the status of some 230,000 draft-eligible students this spring as colleges finish out the academic year.

Dr. Morse Named on ADA Committee

National recognition of effective work done by a KSMA member was given when Carlisle Morse, M. D., Louisville, was recently named to the American Diabetic Association's Committee on Diabetic Detection and Education. Dr. Morse, Chairman of the KSMA Committee on Diabetes, will assume his duties immediately. John S. Reid, M. D., Washington, D. C., is Chairman of the ADA Diabetic Detection and Education group.

New Members of K.S.M.A.

The Association welcomes the following new members:

Bell—Percy C. Zanger, Fonde; Arthur J. Muller, Pineville.

Butler—T. M. Turner, Morgantown.

Calloway—Charles D. Clark, Murray.

Campbell-Kenton—Richard A. Allnut, Covington; James J. Kelly, Ludlow; Robert S. Leake, Covington; William R. McMillen, Covington; Mark J. Reardon, Covington; Glenn M. Shifley, Covington.

Floyd—William D. Osborne, Bypro.

Graves—Mahlon M. Harlan, Mayfield; John H. Monroe, Mayfield; Alfred Ellison, Mayfield; Richard L. Colley, Mayfield.

Hardin—James H. Stuteville, Brooke Army Hospital, Fort Sam Houston, Texas.

Harlan—Morgan E. Scott, Lynch; Jack L. Paradise, Lynch; Isidore Rochlin, Kenvir; Charles E. Hall, Harlan.

Hopkins—R. J. Dancey, Madisonville.

Jefferson—Lawrence A. Davis, Louisville; Fred A. Sawhill, Louisville; Charles D. Yohe, Lakeland.

Jessamine—Joseph R. Griffitt, Nicholasville.

Perry—Ernest A. Golia, Hazard.

Warren—Richard F. Grise, Bowling Green.

County Society Reports

BELL

A special meeting of the Bell County Medical Society was held on April 22, 1952 at 8:00 P. M. at the Chamber of Commerce in Pineville.

Members present were: Dr. Ed Wilson, Jr., Dr. Ed Wilson, Sr., Dr. C. D. Cawood, Dr. Percy Zanger, Dr. James Golden, Dr. J. S. Parrott, Dr. Waller Griffing, Dr. R. F. Porter, Dr. C. S. Scott.

Mr. Ed Smith, County Health Administrator, was present as a guest.

Mr. Smith reported on the progress of the new County Health Department Building and proposed that the Society contribute approximately \$350.00 toward securing chairs for the new room to be used for our future meetings. The state would then contribute twice the amount given by the Society for this purpose. This money, Mr. Smith stated, would have to be collected by May 15. The Society was unanimous in its approval of this plan, and each doctor is to be contacted for his contribution. Dr. Ed Wilson, Sr., was placed in charge of receiving these contributions.

Plans for the coming 15th Councilor District Meeting were discussed. Dr. Ed Wilson, Sr., Councilor for the 15th District, was appointed as Chairman of the committee to work with Dr. George Asher and Dr. James Golden in making arrangements for this meeting.

Announcement was made of the Crippled Children's Clinic on April 24 at the First Baptist Church in Middlesboro. This clinic is to be conducted by Dr. Harry Goldberg of Louisville. Each member was invited to attend and to refer any crippled child he wished.

The program for the evening was on "Tyrotoxicosis," the last of three telephone lectures from the University of Louisville School of Medicine. The program was enthusiastically received and much comment followed its completion.

Respectfully submitted,

C. S. Scott, M. D., Secretary-Treasurer

BOURBON

The Bourbon County Medical Society met in regular monthly session Tuesday, April 22, with all members of the Society present except one. Visitors from Carlisle and Lexington were present.

Dr. Marshall Jones of Lexington, Secretary of the Blue Grass Medical Society, spoke to us

in regard to a colored physician coming to this community.

The question of the Cancer Mobile Unit was brought up and the Society was overwhelmingly in favor of having a visit of this unit some time during the second half of this year. Dr. William S. Morgan was named chairman of the committee in handling arrangements.

We had as our special guest Dr. Clark Bailey of Harlan, Kentucky, President of the Kentucky State Medical Association, who ranged over the subject of medicine in general and Kentucky medicine in particular.

Mr. Barrington Kinnaird, Executive Secretary of our new hospital, escorted us on an inspection tour of the hospital.

Dr. Ojar Podins of the staff of the District No. 3 Tuberculosis Hospital was accepted as a new member of the Society.

Regular meetings for the year have been planned and it is the hope of the Society that we will regain our enthusiasm that once prevailed in the County Society.

B. N. Pittenger, M. D., Secretary

JEFFERSON

The March meeting of the Jefferson County Medical Society was held on Monday evening, March 17, 1952, at the Seelbach Hotel. Forty-five members were present for dinner.

The meeting was called to order at 7:50 p. m., by the President, Dr. R. R. Slucher.

The Secretary read the Necrology Committee's report on the death of Dr. Lawrence Nehil, formerly a member of this Society.

The following other communications were read:

1. Letter from the Corresponding Secretary of Private Duty Nurses, notifying the Society of an increase in their rates from \$10.00 to \$12.00 for eight hours of general cases, effective March 20, 1952. Other rates were increased accordingly.

2. Notice that a plant physician is needed at DuPont Company, Indiana Ordinance Works, Charlestown, Indiana.

3. A letter of thanks from the Woman's Auxiliary for providing them with funds to complete the furnishing of the "Jefferson County Room" in the McDowell House.

4. A letter from Dr. Herbert L. Clay, Jr., Director of Postgraduate training, University of Louisville Medical School, inquiring whether or not the Society wished to again sponsor two

out-of-town speakers for the Seminar to be held on June 2 and 3.

Motion was made by Dr. R. O. Joplin that the Society sponsor two speakers for the Seminar this year. Seconded and carried.

Dr. Joplin brought up again the need for a roster of members of the Society. He outlined a plan, sponsored by Cusicks, Photographers, and Standard Printing Company, whereby photographs of members would be taken at no cost to the doctor other than to buy one copy of the roster. It would be necessary to guarantee the purchase of a certain number of the booklets in order to get them at the price quoted.

There was discussion by several members, and it was suggested that members be polled, so that those not present at this meeting could express their opinion. Dr. Bernard Schneider made a motion that because of the small group present, the matter be tabled until the next meeting. Seconded and carried.

The following new members were elected to active membership: Drs. Donald K. Bailey, Lawrence A. Davis, Fred A. Sawhill, and Charles D. Yohe. To Associate memberships: Dr. George Schuster, III.

The applications of Dr. Alice N. Pickett and Dr. George C. Leachman for Emeritus membership, were approved.

Dr. Bernard Schneider proposed that the Executive Committee consider the possibility of changing the time and location of the meetings of the Society with a view to increasing attendance. Some dissatisfaction with the meals served has been expressed, and attendance has fallen off. He mentioned the possibility of meeting in the auditorium at the new Veterans Hospital. There was discussion by Dr. Alfred O. Miller and Dr. Robert Tate, and motion was made by Dr. Tate that the matter of a meeting place and time be referred to the Executive Committee. Seconded and carried.

SCIENTIFIC PROGRAM 8:10 P. M. "Experiences with Intramedullary Nailing of Fractures." By Dr. K. Armand Fischer. Slides were shown.

Discussion by Drs. Harry Goldberg, M. R. Colbert, K. D. Leatherman, James Robert Hendon, Joseph Heitger and others. Closing remarks by Dr. Fischer.

The meeting officially adjourned at 9:05 p. m., following which a film on weight reduction was shown and comments made by a representative from the Dairy Council.

Robert C. Long, M. D., Secretary

SCOTT

The regular monthly meeting of the Scott County Medical Society was held on Thursday, May 1, 1952, at the John Graves Memorial Hospital in Georgetown, with the following members present: Drs. D. E. Clark, Jr., P. H. Crutchfield, A. F. Smith, H. G. Wells, F. W. Wilt, E. C. Barlow, W. S. Allphin, and H. V. Johnson.

Clark Bailey, M. D., Harlan, was the guest speaker. Mr. Joe Kelly, Hospital Administrator, was also present.

The motion was made and carried to dispense with the reading of the minutes of the previous meeting.

The Secretary then introduced the speaker, Dr. Clark Bailey, Harlan, President of the Kentucky State Medical Association and member of the Legislative Committee of the American Medical Association. Dr. Bailey gave a most interesting and instructive discourse on the "Modern Trends in the Practice of Medicine," and stressed the fact that we must be on the alert every minute to protect the Medical Profession and the welfare of our people. He told us of the work done by the K.S.M.A. and the activities of the different committees. A round table discussion followed his talk.

The Secretary reported this is the Ninety-sixth consecutive meeting of the Scott County Society.

A unanimous vote of thanks was extended to Dr. Bailey for coming before us and giving such a fine talk.

H. V. Johnson, M. D., Secretary

UNION

The regular monthly meeting of the Union County Medico-Dental Society was held at Our Lady of Mercy Hospital in Morganfield at 7:30 P. M. following a dinner and staff meeting.

The meeting was called to order by Wm. Humphrey, M. D., President.

The minutes of the last meeting were read and approved.

The secretary read several communications from the State Medical Association on various subjects.

A communication from Robert Lich, Jr., M. D., regarding the broadcasts and the importance of remittance fees, members present each paid a proportion divided among the membership to clear the docket on the amount owed for the telephone seminar hookup and the telephone bill.

Clinical Results* with Banthine® Bromide

(Brand of Methantheline Bromide)

22 Published Reports Covering Treatment of 1443 Peptic Ulcer Patients with Banthine

Comprising the reports published in the literature to date which give specific facts and figures of the results of treatment

AUTHORS	No. of Patients	Chronic, Resistant to Other Therapy	TYPES OF ULCERS				RELIEF OF SYMPTOMS (Chiefly Pain)				Surgery or Complications ¹	Side Effects Requiring Discontinuance of Drug ²	EVIDENCE OF HEALING			
			Duodenal	Jejunal	Stomal	Gastric	Good	Fair	Poor	No Report			Complete	Moderate	None	No Report
Grimson, Lyons, Reeves	100	100	93	7			80	11	4		5		47		19	29
Friedman	15	15	14			1	5		4	6 ¹			2			13
Bechgaard, Nielsen, Bang, Gruelund, Tobiasen	26	26	21			5	16	4	6				8	6	12	
McHardy, Browne, Edwards, Marek, Ward	162		162				136	12	11		3	1	14	9	7	129
Segal, Friedman, Watson	34	34	34 ¹				14	13			7	2	5		8	14
Brown, Collins	117	99	117				97	7	8		5	8	55	9	8	40
Asher	77		65		7	5	52	9	16			16		9	21	47
Rodriguez de la Vega, Reyes Diaz	5	4	5				4		1					3	2	
Winkelstein	116	116	102	8		6	102		14				53		18	45
Hall, Hornisher, Weeks	18	18	18				11		1	6 ¹			18			
Maier, Meili	38	38	24			14 ¹	27	7	4 ¹				10	2	5	21
Meyer, Jarman	25	18	25				21		4							25
Polth, Fromm	37	37	37				33	3	1				33	3	1	
Plummer, Burke, Williams	41	41	41				36		5				38		3	
McDonough, O'Neil	104	100	104				63	10	31			11	4		11	89
Broders	60	60	58		1	1	35	19	6				10	1	49 ¹	
Legerton, Texler, Ruffin	11		11				11									11
Holoubek, Holoubek, Langford	76	69	76				35	27	10		4	10	26		10	36
Ogborn	42		39	2		1	42 ¹									42
Shaiken	48	48	48				33	10	3		2		33	10	3	
Johnston	145	145	145				143		2			2	143		2	
Rossett, Knox, Stephenson	146		141			5	146					41 ¹⁰	53			93
TOTALS	1443	968	1380	17	8	38	1142	132	131	12	26	54	552	52	179	634
PERCENTAGES		67.8	95.6	1.2	0.6	2.6	81.3	9.4	9.3			3.7	70.5	6.6	22.9	

1. Not included in tabulations.

2. Included in "Relief of Symptoms" as "Poor" and

in "Evidence of Healing" as "None."

3. Four had no symptoms when Banthine therapy was begun.

4. Of which seven were penetrative lesions and five partially obstructive.

5. No symptoms were present in four.

6. Two with symptoms only, no demonstrable ulcer.

7. Three were psychopathic patients and one had a ventricular ulcer of the lesser curvature.

8. Roentgen findings after treatment period of two weeks; forty-seven had duodenal deformity.

9. All returned to work within a week.

10. In these four, after relief of symptoms, Banthine was discontinued because of urinary retention.

During the past two years, more than 200 references to Banthine therapy in peptic ulcer and other parasympathotonic conditions have appeared in medical literature. Of these reports, 22 have presented specific facts and figures on the results of treatment in a total of 1,443 peptic ulcer patients, 67.8 per cent of whom were reported as chronic or resistant to other therapy. These results are tabulated above and show:

"Good" relief of symptoms was obtained in 81.3 per cent of the 1,405 patients on whom reports were available.

"Complete" evidence of healing was obtained in 70.5 per cent of the 883 patients on whom reports were available.

In all but 9.7 per cent, relief of pain was "good" or "fair." In all but 22.9 per cent, evidence of healing was "complete" or "moderate."

During treatment, 26 patients required surgery or developed complications other than ulcer which required discontinuance of the drug before results could be evaluated.

Of the remaining 1,417 patients, only 3.7 per cent experienced side effects sufficiently annoying to require discontinuance of the drug.



*Volume containing complete references, with abstracts of 39 additional reports, will be furnished on request by

G. D. SEARLE & Co., P. O. Box 5110, Chicago 80, Illinois.

The matter of another series of broadcasts for next year will be further discussed at the next meeting after the members have had some time to think over the advisability of further broadcasts for Union County.

The secretary read a communication from John B. Floyd, Jr., M. D., regarding the Cancer Clinic. Dr. Floyd stated the mobile cancer diagnostic clinic has been scheduled for Union County July 9-10-11. The clinic will be held in the county health department.

The final broadcast came through very clear, the subject was timely, instructive and well presented.

Members present were Drs. Carr, Conway, Cottingham, Humphrey, Graves, Higginson, Smith, Puryear, and Welker.

A. W. Andreasen, M. D., Secretary-Treasurer

In Memoriam

ALBERT LEE EDDY, M. D.
1866 - 1952

Dr. Albert Lee Eddy, who practiced for 61 years in Louisville, Kentucky, died May 2, 1952, at the age of 86. He was in continued active practice until a few months before when a heart attack forced him to retire. He was the son of a physician and a graduate from the Kentucky School of Medicine in 1891, and took a post-graduate course at the University of Michigan. Prior to 1930 and for 37 years he was part-time teacher of pathology and histology at the University of Louisville Medical School and in the College of Arts and Sciences, biology.

LEE P. MOLLOY, M. D.
Paducah
1875 - 1952

It is with great regret that the McCracken County Medical Society is again called upon to note the passing of one of its members.

Dr. Lee P. Molloy was born and reared in Lyon County and died at Riverside Hospital on April 3, 1952. He was the son of the late Mr. and Mrs. James Molloy of near Eddyville.

Dr. Molloy was graduated from University of Louisville School of Medicine in 1907. He practiced a year at Dulaney in Caldwell County, moving to Kuttawa about 1908. He practiced there until 1919 at which time he came to Paducah.

D. Molloy was a member of the McCracken

County, Kentucky and American Medical Societies. Several years ago he was active in the Masonic Lodge, Elks Club and Lions Club.

He is survived by three sons, Cecil P. Molloy of Bandana, Lyle Molloy of Paducah, and Lee P. Molloy of St. Louis; a daughter, Dr. Lorraine Molloy Roberts of DeRidder, La.; a sister, Mrs. G. L. Gray of Paducah, and four grandchildren.

NOW, THEREFORE, BE IT RESOLVED, that the McCracken County Medical Society record an expression of sorrow in his passing and that a copy of these resolutions be spread on the minutes, that a copy be sent to his family, and a copy be sent to the Kentucky State Medical Journal for publication.

April 22, 1952.

Committee on Resolutions
Errett Pace, M. D.
Bob C. Overbey, M. D.
H. D. Abell, M. D.

ALLEN H. SHEMWELL
Paducah
1884 - 1952

It is with great regret that the McCracken County Medical Society is again called upon to note the passing of one of its members.

Dr. Allen H. Shemwell was born at Birdsville, in Livingston County, and died at Illinois Central Hospital on February 12, 1952.


He was the son of the late Dr. F. A. Shemwell, for many years a physician in Livingston County. Dr. Shemwell was graduated from St. Louis School of Medicine in 1910 and came to Paducah after serving his internship in St. Louis. He was a medical officer during World War I and took an active part in rebuilding Riverside Hospital here after the 1937 flood. He was a member of the American Medical Association, Kentucky State Medical Association and McCracken County Medical Society.

He is survived by his wife, Mrs. Lillie K. Shemwell; and a son, Dr. Frank Allen Shemwell.

NOW, THEREFORE, BE IT RESOLVED, that the McCracken County Medical Society record an expression of sorrow in his passing and that a copy of these resolutions be spread on the minutes, that a copy be sent to his family, and a copy be sent to the Kentucky State Medical Journal for publication.

February 16, 1952.

Committee on Resolutions
Errett Pace, M. D.
E. W. Jackson, M. D.
Bob C. Overbey, M. D.



adrenal cortical reserves

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LEWIS EDWIN YOUNG, M. D.

Paducah

1882 - 1952

Dr. Lewis Edwin Young was born in McCracken County, on September 11, 1881. He graduated from the Hospital College of Medicine in 1903 and passed away on February 27, 1952.

Immediately following his graduation, Dr. Young located in Paducah and joined the McCracken Medical Society. He remained in Paducah until 1911, when he moved to the Milan Community in McCracken County where he, with the constant help of his devoted wife, lived and labored throughout the remainder of his life.

He was a typical country doctor and averaged 30,000 miles a year calling upon the ill and injured, and delivered thousands of babies. In 1951 his friends and neighbors celebrated his birthday and the first child he delivered 48 years ago attended the celebration.

THEREFORE, BE IT RESOLVED, that we, the members of the McCracken County Medical Society, in recording the death of Doctor Young, be reminded that we have lost a physician of the old school, a country doctor, who was representative of that honored group of physicians who by their own deeds caused doctors to be revered above all others and who made medicine, with the possible exception of the Ministry, the greatest and the most highly respected profession in the world.

BE IT FURTHER RESOLVED, that a copy of this resolution be placed in the minutes of this Society, a copy be sent to the Kentucky State Medical Association and a copy to the family of Doctor Young.

April 23, 1952.

Committee on Resolutions,

E. W. Jackson, M. D., Chairman

H. D. Abell, M. D.

J. M. Hunt, M. D.

BOOK REVIEWS

THE FIGHT AGAINST TUBERCULOSIS: An Autobiography by Francis Marion Pottenger, M. C., Medical Director of the Pottenger Sanatorium, Monrovia, California, Professor Emeritus of Medicine (Diseases of the Chest) of the Medical Department of the University of Southern California. He served as Vice-President, California State Board of Public Health. Henry Schuman, Inc., 20 East 70th Street, New York 21, N. Y. Publishers. Price \$4.00.

This book is written for the general reader but is equally interesting to the physician as he recalls the wide and varied interests that marked the impressions of his life and helped him to become one of the pioneers in conquering tuberculosis.

His contributions include the discovery of new diagnostic measures and aid in the development of a rational therapy and sanatorium regimen.

PRACTICAL ESSAYS ON MEDICAL EDUCATION AND THE MEDICAL PROFESSION IN THE UNITED STATES by Daniel Drake, M. D., The Johns Hopkins Press, Baltimore 18, Maryland, Publishers. Price \$2.50.

The first edition of this important book, published one hundred and twenty years ago, is now extremely rare. The present edition, facsimile of the original, has a brief introduction by Dr. David A. Tucker, Jr.

This book has been called "far and away" the best one on medical education written in the United States. As such it has, even today, a timely message which could be profitably read by all physicians.

This year marks the centennial of Drake's death and the Kentucky State Medical Association is honoring his memory by calling its coming meeting: The Daniel Drake Memorial Meeting.

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Cortisone and ACTH in the Treatment of Chronic Arthritis

RUSSELL L. CECIL, M. D.

New York City

Internal medicine today is largely concerned with the treatment of chronic disease, and in that group chronic arthritis, because of its great prevalence, occupies an important place. Chronic arthritis presents additional problems because physicians have not yet learned how to treat any of the more important varieties with conspicuous success. Of the various forms of chronic arthritis recognized, I wish to consider in the present address only the four most important forms, namely, gouty arthritis, osteoarthritis, rheumatic fever and rheumatoid arthritis. All four of these conditions are frequently encountered in medical clinics and in physicians' offices, and constitute what might be called "The Four Horsemen of the Epiphyses." Every year advances are being made in all four of these fields, but in all fairness it must be stated that we still have a long way to go before the ideal therapy is achieved.

In this brief review it will be possible to touch only on recent advances, chiefly therapeutic, in the arthritis field. Most emphasis will be placed on the role of cortisone and ACTH in these four major arthritis syndromes.

Cortisone and ACTH have very much the same physiological effect; they both induce a state of hyperadrenalism, ACTH by stimulating the adrenal cortex to overproduction of cortisone and other adrenal steroids; and cortisone by supplementing that manufactured by the adrenal cortex in the natural course of events. ACTH

acts more quickly than cortisone, but has a short-lived action and must therefore be administered every six hours. Efforts are now being made to find a vehicle for ACTH which will be more slowly absorbed. ACTH has the great advantage at the moment of being readily available, which is not true of cortisone. Both hormones are usually administered by the intramuscular route, though variations have been introduced in the method of administration. Several writers¹ have expressed considerable enthusiasm for the oral administration of cortisone in the form of 25 mgm. tablets. If the dose by the oral route is 25 per cent greater than that by the intramuscular route, the therapeutic results are usually equally good, though there are exceptions. Recently Thorne² has been giving ACTH intravenously by the drip method in daily doses of 20 to 25 mg. in 1000 cc. of glucose saline solution over a six hour period. This has certain advantages in that great economy in the use of the steroid is achieved, but of course such a procedure has to be carried out in a hospital. Cortisone has the advantage of being administered usually only once in twenty-four hours. The daily intramuscular dose of ACTH is usually 60-100 mg., which may be maintained for several weeks and then gradually reduced or given at less frequent intervals. The initial dose of cortisone is usually 200-300 mg. Hollander³ has recently reported rather promising results from the administration of Compound F directly into the affected joint cavity of the rheumatoid patient. Strangely enough, cortisone, or Compound E, had no beneficial effect

Read before the Ephraim McDowell Memorial Meeting, the Centennial of the Kentucky State Medical Association, Louisville, October 2-5, 1951.

when so injected. Cortisone has one advantage over ACTH in that it is less likely to produce undesired side effects and requires only a single daily injection. Some writers have tried alternating cortisone and ACTH; the advantage of this has not yet been clearly established. Whichever hormone is used, the treatment is continued until marked improvement or remission takes place, at which time the dose is gradually reduced or is given at less frequent intervals.

Among the more important physiological effects of adrenal cortical therapy are the following: retention of sodium and water; excess excretion of potassium; rapid drop in sedimentation rate; rise of hemoglobin; rise of red cell count; drop in total eosinophile count; and restoration of albumin-globulin ratio to normal. Large doses of cortisone may produce unpleasant symptoms at times; for example, with excess retention of sodium and fluids, oliguria, edema and even cardiac embarrassment may take place. Symptoms of Cushing's syndrome may appear after treatment has been continued for a certain length of time. In young women the menstrual cycle may be temporarily interfered with. Euphoria may be excessive and lead to variations in mood and psyche, or even to a real psychotic state. It has been customary to start hormone treatment in the hospital, though in the writer's opinion this is rarely necessary except in the case of individuals whose general physical condition is poor. It may be necessary to restrict salt and in some cases to administer potassium chloride by mouth, 1 gram three times a day, as a precaution against calcemia. Certain laboratory tests are useful in following the course of hormone therapy. In addition to the red and white blood cell count, sedimentation tests should be made frequently and some writers advocate a total eosinophile count as a test for the responsiveness of the adrenal cortex. The urine must be watched for glucose, and frequent determinations of blood pressure and body weight are important. Blood sodium and potassium levels are desirable but difficult to obtain, and are not absolutely essential as a routine. The same is true of electrocardiograms. It has been our impression, and that of others as well, that men tolerate both cortisone and ACTH more readily than women.

Contraindications to the use of cortisone and ACTH are: cardiac decompensa-

tion or advanced cardio-renal disease; malignant hypertension; severe diabetes mellitus; active tuberculosis and other infections; active peptic ulcers; and a history of any mental disturbance, even of a mild character.

Cortisone and ACTH have a tendency to mask the physical signs of infection. The patient may develop lobar pneumonia or even peritonitis, and show very few constitutional symptoms. These agents interfere with the immune mechanism in some unknown way and still more important, as shown by Ragan and his co-workers, cortisone interferes with the growth of granulation tissue, thus checking the healing mechanism in wounds. Large gluteal abscesses have appeared on the buttocks of patients being treated with cortisone intramuscularly. Six of these have been among our own series. Because of the rather high incidence of these abscesses, sterile precautions should be carried out in the most meticulous manner.

Gouty Arthritis

There is no cure for gout, though the acute symptoms are usually readily relieved. The commonest manifestation of gout is acute gouty arthritis, which usually attacks the metatarso-phalangeal joint of the great toes or the instep of one or both feet. Acute attacks of gouty arthritis are often unrecognized by the physician and consequently many of these patients receive improper treatment.

Colchicine is still the drug of choice for the treatment of acute gout. One tablet (0.5 mg.) should be taken every hour as soon as the first symptoms appear, or two tablets can be taken every two hours until symptoms of gastrointestinal irritability, such as nausea, vomiting and diarrhea make their appearance. If for any reason colchicine by mouth fails to relieve the joint symptoms or causes severe gastrointestinal disturbance, colchicine can be given very effectively by the intravenous route in 0.5 mg. doses in combination with sodium salicylate.

ACTH can be administered in divided doses of 100 mg. intramuscularly. ACTH may be quite effective in the occasional patient who responds slowly and incompletely to colchicine. On the other hand, ACTH may be ineffective in patients who do well on colchicine. An exacerbation of gouty arthritis, the so-called rebound reaction, may occur a day or two after the remission which has been induced by

ACTH. Relapse is probably due to inadequate or insufficiently prolonged administration of the agent. In some clinics acute gout is now being treated by a combination of colchicine and ACTH or cortisone, continuing the administration of colchicine for some time after the acute symptoms have subsided in order to prevent recurrence. Talbott⁴ considers cortisone inferior to ACTH in the treatment of acute gout, and that has been our experience. It would be difficult to say just how frequently hormone therapy would be indicated in gouty arthritis, but I would hazard the guess of not more than one in twenty cases.

The problem in *chronic tophaceous gouty arthritis* is to minimize the deposition of urates and, if possible, to mobilize such deposits when once formed. Colchicine does not prevent the deposition of urate in the tissues since it has no effect on the excretion of uric acid. Salicylates, however, do increase uric acid excretion, particularly when combined with certain agents such as sodium bicarbonate. For this reason it is good practice to give aspirin or sodium salicylate in conjunction with colchicine, not only to acute gouty patients but in chronic gout as well.

The real problem of the physician in treating gout is to reduce the frequency of acute attacks. The prevention of acute attacks may be only partially successful, but if the patient follows the regime outlined faithfully, the number of attacks can be considerably reduced in almost every instance. The two drugs most useful in the prevention of gouty arthritis are colchicine and salicylates. Most gouty patients should have some colchicine during the symptom-free periods, particularly if they are having more than one or two attacks a year. The usual dose is 0.5 mg. two or three times a week, but those who are having frequent attacks should take 0.5 mg. a day throughout the year. Along with colchicine, three grams of salicylate may be taken on two or three days of each week.

There is still considerable disagreement among authorities as to the role of the low purine diet in the treatment and prevention of gouty arthritis. Gutman⁵ believes that since not only purines, but all proteins, carbohydrates and fats must be regarded as potential precursors of uric acid, absolute control of urate formation by dietary restriction of the gouty subject is impossible. He believes, however,

that an attempt should be made to minimize the rate of uric acid production, at least in patients with chronic gouty arthritis and in those subject to frequent recurrences of acute gout. He therefore restricts nitrogen in the form of proteins as well as purines, and for several years he has used diets which are limited to dairy products, cereals, eggs, nonleguminous vegetables and fruits. Hench⁶ goes along with Gutman in maintaining that a low purine diet is important in the prevention of gout. He believes that a low fat and low purine diet are desirable, but that otherwise a balanced diet is acceptable. All authorities agree that any food stuff that is proved to be a precipitating agent in the particular patient should be avoided.

Two new drugs, carinamide and benamid, have recently been introduced into the treatment of gout⁷. Both of these drugs cause a marked increase in the excretion of urinary urates. Benamid is preferable to carinamide as it causes less gastro-intestinal disturbance. The dose of benamid is two grams daily, and when this is kept up for several weeks, the blood uric acid level may be cut approximately in half. Benamid has no analgesic effect, nor has it any value in the treatment of acute gout.

Osteoarthritis

Osteoarthritis, or so-called degenerative joint disease, is almost universally present to some degree in the aged, but can be practically asymptomatic. When the aging joint is abused, symptoms usually appear. Severe nonarticular osteoarthritis is almost always the result of congenital malformation or previous joint damage either from trauma or infection.

Osteoarthritis is temporarily relieved, but not cured, by rest and the application of heat. Observed most frequently in the knees, hips and spine, it is often quite resistant to therapy.

Boots⁸ has recently reported beneficial results from cortisone in 12 cases of osteoarthritis of the hip, and we have been able to confirm this observation in some, but not all, of our own patients. No doubt similar benefit could be obtained in the more stubborn cases of osteoarthritis of the knee or spine. The relief in all instances is temporary; that is, the pain and stiffness return when cortisone is discontinued, and the number of cases treated is still small.

Osteoarthritis, when advanced and crippling, often necessitates surgical intervention. In recent years, orthopedic surgery has made important advances in this field, and when other measures fail, the patient with osteoarthritis should always have the benefit of an orthopedic consultation.

Osteoarthritis of the hip is the most painful and stubborn form of osteoarthritis. Several operations have been devised for the relief of this condition.

(a) Neurectomy. The hip joint is supplied by branches from the femoral, obturator and sciatic nerves. If either or both the obturator and the branch from the sciatic nerve to the quadratus femoris muscle are severed, pain in the affected hip is often relieved for a period of two to three years.

(b) Another comparatively simple measure is the injection of potassium acid phosphate directly into the affected hip joint. This particular form of intra-articular therapy is technically a little tricky and a preliminary diadrasit injection may be desirable, especially in inexperienced hands. The injection must be repeated several times. When properly done, this treatment has proved helpful in some cases.

(c) In severe hip cases (if unilateral), various plastic operations have been tried with varying degrees of success. Perhaps the best known of these is the so-called vitallium mold orthoplasty in which the femoral head is remodelled and covered with a vitallium cup. It may also be necessary to construct a new acetabulum. Satisfactory results cannot always be promised, though in many cases the patient is well pleased. Flexion of the hip may be good even after a lapse of ten or twelve years; however, even in the most successful cases the patient must walk with a cane and convalescence from the operation is a long one. More recently a nylon cup has been tried in place of vitallium, with promising results.

There are several new plastic procedures now being introduced by the orthopedists. Judet⁹, a French surgeon, completely removes the head of the deranged femur and substitutes a plastic artificial head. In this operation the acetabulum is usually not disturbed. This is a fairly simple surgical procedure, but no one can predict what the end results will be. Other appliances made of vitallium or stainless

steel to replace the femoral head are being tried out in this country.

(d) Finally, there is fusion, or so-called arthrodesis, for severe cases. This operation is limited pretty much to the male arthritic, as it always results in a stiff, though painless, hip.

(e) In severe cases of osteoarthritis of the knee, debridement operations are frequently resorted to and have proved beneficial. Osteospondylitis is treated chiefly by rest and orthopedic braces and corsets. Surgery is rarely resorted to except in severe cases when spinal fusion may be required.

Rheumatic Fever

Several important advances have been made in recent years in the prevention and treatment of rheumatic fever. The following facts with respect to the prophylaxis and therapy of rheumatic fever may be summarized as follows:

1. To prevent rheumatic fever, it is necessary to prevent the hemolytic streptococcal infection which practically always precedes the onset of rheumatic fever. Originally this was accomplished by the daily administration orally of sulphadiazine 0.5 to 1 gm. daily from September to June. Such a program will usually prevent rheumatic fever in both epidemic and endemic form. More recently, similar favorable results have followed the oral administration of penicillin, either 800,000 units in four equal parts daily for seven days each month, or a daily regime of 200,000 units divided into two doses administered on awakening and at bedtime. Both techniques require the same total dosage. The monthly seven day course may be more convenient and is more likely to overcome the streptococcal carrier state.

2. Prevention of rheumatic fever in patients who have already been attacked by a streptococcal infection presents more of a problem. However, the investigations of Rammelcamp and his co-workers¹⁰ provide strong evidence that the incidence of rheumatic fever can be drastically reduced if hemolytic streptococcal infections are treated promptly with adequate amounts of penicillin. Whenever it is desirable to afford maximal protection against the development of rheumatic fever, penicillin should be administered daily for a seven to ten day period. The drug may be given intramuscularly, either in a

single daily injection of 300,000 units of the procaine salt, or in individual divided doses of 20,000 to 50,000 units of the aqueous solution administered at no greater than three hour intervals throughout the entire twenty-four hour period. The earlier in the course of the streptococcal infection the penicillin is started, the better chance that the antibiotic therapy will protect against rheumatic fever.

3. In the treatment of rheumatic fever, sodium salicylate and acetyl salicylic acid still hold first place. However, cortisone and ACTH have already attained some popularity in this field. I heard a prominent rheumatologist say only recently that if his own child had rheumatic fever, he would certainly give it cortisone, probably in combination with salicylate therapy. Certainly both cortisone and ACTH have a striking effect on the fever, arthritis and general toxic state of rheumatic fever. These effects, however, are little if any more striking than those which can be induced in most instances by full doses of salicylates; and furthermore, if hormone therapy is discontinued prematurely, the symptoms of rheumatic fever promptly return.

There has been considerable debate as to the effectiveness of the new hormones in the *prevention and cure of rheumatic carditis*. Salicylates do not modify to any degree the onset and course of carditis. It is obvious, therefore, that the question of whether ACTH and cortisone favorably affect the course of rheumatic heart disease is of prime importance to the practitioner. On the positive side, Wilson and Helper¹¹ have recently described the effect of ACTH on eleven patients admitted for acute rheumatic carditis of four to twenty-eight days duration. All of the patients showed termination of progressive signs and symptoms of acute carditis in a few days and all became ambulatory within a period of two to four weeks. Barnes,¹² reporting on ten cases from the Mayo Clinic, obtained somewhat different results. Five of Barnes' patients developed systolic apical murmurs in spite of hormone therapy. Similar results have been observed in a group of eighteen patients treated in Bellevue Hospital by the Study Group on Rheumatic Diseases of the New York University College of Medicine¹³. Of these, twelve patients were in their first attack, while the other six had experienced one or more previous attacks. In all eighteen patients the fever fell

rapidly to normal and symptoms of rheumatic toxicity disappeared. Of the seven patients who had polyarthritis, the joints returned to normal in two to seven days. However, in every instance murmurs considered to be indicative of organic heart disease, which were present on admission, persisted even in patients who began hormone therapy within eight to ten days of the onset of the first rheumatic attack. Of the total eighteen patients, carditis was considered to be markedly improved in nine; moderately improved in three; slightly improved in four; unimproved in two. The disagreement in these figures makes it difficult to evaluate cortisone and ACTH in rheumatic fever and even more in rheumatic carditis. Much more clinical research is needed in this field.

From this brief summary we must conclude that the question of the effectiveness of ACTH and cortisone in the treatment of rheumatic carditis is far from settled. Pre-existing cardiac injuries, such as valvular lesions and cardiac enlargement, are not benefitted by hormone therapy. It is also clear that ACTH or cortisone, administered in the presence of congestive heart failure, demands special care to ensure that the sodium and water retaining tendency of the hormones does not dangerously increase the failure.

Rheumatoid Arthritis

Rheumatoid arthritis is a chronic systemic disease of unknown etiology. The joint manifestations are probably not due to actual infection, though it is quite possible that as in rheumatic fever, infection may play a part in initiating the disease process. The standard treatment of rheumatoid arthritis is familiar to most practitioners. Rest, physiotherapy, rehabilitation, exercises, all have their important part, and certainly psychotherapy is not to be deprecated. We are interested today in the newer phases of treatment, but before discussing cortisone and ACTH, I wish to say a word about gold therapy.

The treatment of rheumatoid arthritis with gold salts has been in active use in this country now for more than fifteen years. It has become a routine form of therapy in many arthritis clinics. There are a few rheumatologists, however, who still are skeptical about its value, feeling that just as favorable a result can be obtained by rest, physiotherapy and exercises. It may be many a day before we

possess the skill to cure rheumatoid arthritis permanently. What the physician now really attempts to do is to throw the patient into a remission. It is our conviction that this can be done in many cases with gold salts, particularly if administered early in the course of the disease. In a recent study by the author in collaboration with Chester Adams¹⁴, it was found that in 106 patients with rheumatoid arthritis, treated during their first year of illness by chrysotherapy, remissions occurred in 66 per cent; whereas in 83 control cases treated by other methods during the first year of the disease, only 24 per cent had remissions. On the average, remissions were noted ten months sooner in the gold treated cases than in the controls (7.1 months vs. 17.1 months). Gold therapy is always attended by certain dangers which militate against its popularity. However, if the patient is watched carefully and regular examinations of the blood and urine are made, serious reactions can nearly always be avoided. The most common manifestations of gold intoxication is dermatitis, and when this appears, British antilewisite (BAL), if administered promptly, will accelerate the elimination of the gold salts and hasten the disappearance of the gold dermatitis as well.

Cortisone and ACTH act upon the patient with rheumatoid arthritis very much the same way as they act in rheumatic fever. There is marked and rapid amelioration of the patient's symptoms, rapid decrease in swelling of the joints, improvement of appetite and replacement of malaise with euphoria. In many cases flexion deformities disappear, and in some cases subcutaneous nodules shrink or disappear completely. Unfortunately, when these agents are discontinued, signs and symptoms of arthritis usually begin to reappear within twenty-four to forty-eight hours in 70 per cent of cases. In a few exceptional cases, remissions have persisted for as long as several weeks or months. When these agents are readministered, prompt remission is usually again induced. Bayles¹⁵ and his co-workers have recently reported that by giving massive intramuscular doses of 500 mg. of cortisone daily for two to four weeks, complete remission can be induced and maintained for a period of one to three months after the drug is discontinued. We have not tried this method of producing long

remissions. It sounds terrifying, but promising.

The administration of cortisone or ACTH for a short course of time is a comparatively simple procedure. It is when these hormones are continued over many months that problems, sometimes serious, arise. It is a fact, however, that except for the comparatively few patients who do well on small doses (50 mg. of cortone 3 days a week), a majority of patients have to discontinue (or choose to discontinue) hormone treatment after a certain length of time. Why?

The hormone begins to lose some of its efficacy. Swollen joints reappear and the original euphoria is replaced by depression. A "booster" dose will check these symptoms temporarily, but the booster cannot be continued indefinitely. Along with this loss of efficacy, there often develops an alteration in psyche or a real melancholic state which may persist for some time, even after the hormone is discontinued.

When the suboptimal doses are introduced, symptoms reappear and there is much disappointment. At this point, the patient, of his own volition, may decide to discontinue the hormone altogether. No doubt the expense factor enters into the picture to a considerable degree.

Finally, there are the other well recognized side effects which may necessitate the discontinuance of treatment. The most important are marked retention of sodium and water with possibly some evidence of cardiac decompensation, Cushing's syndrome, lighting up of old infections, or abscess formation in the buttocks, hemorrhage from unsuspected peptic ulcer and marked depression. Hirsuties and amenorrhea have not been a serious problem in our experience.

What actually happens to the rheumatoid patient when cortisone or ACTH are discontinued? One of three things can happen.

1. In a few rare instances the patient continues in remission or in a greatly improved state so far as the joints are concerned. In our experience this is indeed a rare occurrence in true rheumatoid arthritis. In some atypical forms of acute or subacute infectious arthritis, or occasionally in rheumatoid arthritis, a more or less prolonged remission occurs, but in well established cases it practically never happens.

2. In the majority of cases the patient quickly reverts to his previous status. However, he has in addition to his swollen and painful joints a great sense of disappointment and frustration and in many of these patients a real emotional depression occurs which is probably in part due to the cessation of the hormone.

3. A so-called "rebound reaction" occurs. This is indeed an unfortunate situation for the patient's arthritis returns in a more severe state than that which existed before cortisone or ACTH were administered. In our practice and clinic we have seen a number of these patients. The situation is embarrassing to the physician and extremely bad for the morale of the patient. This is the point at which the physician frequently loses a good patient unless he possesses more than the average amount of tact or unless the patient is blessed with a very confiding disposition.

Combined Gold and Hormone Therapy

About a year ago we decided that because of the prompt relapse which occurs after discontinuation of cortisone or ACTH, it might be well to combine gold therapy with hormone therapy. We have undertaken this on about twenty cases. The results in brief have been disappointing. In fact, in some cases we have had the impression that the patients did much better on either of these agents alone than with the two combined. We have no reason or explanation for this failure. These cases will be reported in detail at a later date.

Treatment of Rheumatoid Arthritis with Post-partum Plasma

Granirer¹⁶ has recently reported that sustained remissions can be induced in rheumatoid arthritis by the administration of post-partum plasma. There were no toxic effects and the remissions which followed cessation of this therapy sometimes were prolonged for two years. Granirer's studies are interesting, but have not yet been corroborated in other clinics. The obvious difficulty in attempting this type of therapy is the problem of obtaining a regular and adequate amount of post-partum plasma.

Treatment of the Clinical Variants of Rheumatoid Arthritis

Response of patients with Still's disease, Felty's syndrome and rheumatoid spondylitis is quite similar to that observed in

rheumatoid arthritis. So far as rheumatoid spondylitis is concerned, my first choice would still be deep x-ray therapy, though cortisone is spectacular in some cases. This is also true, to a lesser extent, in the treatment of psoriatic arthritis. Reiter's syndrome has been reported as responding very favorably to cortisone therapy¹⁷.

Therapeutic Value of Other Steroids

The dramatic effect of cortisone and ACTH in the treatment of various rheumatic conditions has spurred efforts toward the isolation of other steroid agents which might also prove effective. Thus, testosterone propionate and pregnenolone (the 3-hydroxy-analogue of progesterone) have both been reported as highly efficacious in the treatment of rheumatoid arthritis. However, in the hands of other observers, including the writer, these agents have been very disappointing. More recently Swedish workers¹⁸ have reported success with the combined use of desoxycorticosterone and Vitamin C. The experience of other investigators, as well as our own, has not corroborated these claims. From the experimental work by Selye, the use of desoxycorticosterone as a therapeutic agent for arthritis would not appear to rest on a very rational basis. Extracts of the whole adrenal cortex have also been unsatisfactory.

Summary

In summary it may be said that while cortisone and ACTH have made their most impressive showing in the treatment of rheumatoid arthritis, these agents may serve a useful function in the treatment of rheumatic fever, and to a lesser extent in the therapy of osteoarthritis and gout. Much more clinical investigation will have to be carried out, however, in combination with careful follow-up studies, before a final decision can be reached as to their proper role in the various forms of chronic joint disease.

What does the future hold for hormone therapy in rheumatoid arthritis? In the first place, I think that the great majority of students of rheumatoid arthritis will agree that this is not essentially a disease of adrenal dysfunction. For that reason it seems doubtful to me if rheumatoid arthritis will ever be cured by the production of hyperadrenalism. Does that mean that rheumatoid arthritis is an incurable disease? The answer is no, for any disease in which there occur spon-

taneous remissions should be susceptible to a permanent cure if we have the right key to the problem. The observations of Hench and Kendall¹⁹ have had a wonderfully stimulating effect on the study of rheumatoid arthritis and allied conditions. If they have not produced a cure, their important contribution has at least opened a door which may lead to an eventual solution of this difficult problem.

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Some Encouragements in Cancer Surgery

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When your Program Committee honored me with an invitation to take part in this Centennial Celebration of the Kentucky State Medical Association because I was one of the two living ex-presidents of the American Medical Association from Kentucky I turned over in my mind a number of possibilities for a presentation and inevitably came back to the subject of 'Cancer' because it is one of the most frequent lesions which the Profession is called upon to fight and secondly: because of my intense and long time interest in gastro-intestinal cancer. With the present day wide-spread propaganda objectives to acquaint individuals with the early symptoms of this ailment it seems to me not amiss to dwell briefly on some of the more encouraging phases of the subject and therefore I chose as a title, "Some Encouragements in Cancer Surgery," a title by the way, which was the

subject of a Monograph some years ago by the late Mr. Grey Turner of New Castle-Upon-Tyne, England.

The yardstick by which a surgeon customarily measures his handiwork is post-operative longevity and with the extension of the perimeter of surgical attack more and more statistical studies indicate a larger and larger percentage of cases of cancer in all locations of the body which are living a longer time and living a functional life. It is important that the surgeon recognize that his obligation in the extension of life entails a certain degree of preservation of useful existence and that a brilliant surgical feat which leaves the patient a helpless burden is not by any means the ultimate in success.

I have picked out some cases of breast cancer, stomach cancer and colon cancer upon which I have operated successfully and in each instance I have tried to make the selection for some definite reason and not just because of the number of years following their operation.

CASE No. 1—Mrs. L. C. Age 37, 11 Yrs.
P. O. L&W-48

Diag: Carcinoma of rt. breast.

Oper: Radical mastectomy 1-6-40.

Path: Carcinoma simplex (Anaplastic)

No glandular metastases.

I present this woman for two reasons: First, she is young. Second, she was obese. A radical mastectomy by the Halstead-Hanley technique was done and the Pathologist reported no glands involved. She had another lesion which entered into the problem—a large fibroid. Nothing was done about this because it apparently was a single tumor and her periods were practically normal; however, two years after the mastectomy, because of the increasing size of the tumor and prolongation of menstruation, I did a supravaginal hysterectomy, preserving both tubes and ovaries. Obviously there is some question of whether or not the ovaries should have been removed. I am not unaware of the tendency in certain Clinics to do bilateral-oophorectomy either by surgery or irradiation on women in the child-bearing group; however, it has never seemed to me a proven fact that this is definitely worth while and until more statistical data are available it seems best to me to avoid this procedure. I believe the use of hormones should be limited to those cases with metastatic lesions whether they be osseous or in soft tissue and it has not seemed worth while to use irradiation routinely, but only on cases where definite glandular involvement is demonstrated and where the grade of the growth is high. Even here I think it is of questionable value.

CASE No. 2—Mrs. O. P. C. Age 64, 18 Yrs. P. O. L&W-82.

Oper: Carcinoma rt. breast.

Oper: Oct. 28, 1933.

Path: Adenocarcinoma of breast c/
metastases to axilla.

This woman was operated upon at the age of 64 and glandular metastases were demonstrated in her axilla. She had a radical Halstead-Hanley type of procedure followed by irradiation and is well now at the age of 82—18 years post-operative without any evidences of return. Numerous such cases as this can be demonstrated I think in everyone's practice and where the grade of the growth is low—the end results are extremely high for 5 and 10 year cures.

CASE No. 3—Mrs. T. P. H. Age 65, 11 Yrs. P. O.

Diag: Ca. left breast. Had known tumor mass to be present for 3 yrs.
Had hypertension 230-140.

Oper. 8-5-40 Simple amputation of breast.

2nd Op: 7-5-46, 5 Yrs. later. Removal of pectoral muscles & dissection of axilla for large axillary metastases.

Died 2 Yrs. later of stroke.

I discuss this case to demonstrate what I think was definitely a questionable surgical decision on my part, perhaps involving the medical consultant as well. You will note that she had a hypertension of 230-140. Furthermore she had known of the tumor mass for three years. I could feel no glands in the axilla, but I think the presence of the mass for three years should have been warning that it was a slow growing and probably a low grade malignancy. Because of the hypertension I did a simple mastectomy and the patient lived 5 years without any evidence of recurrence or without difficulty until she returned with a mass in her axilla which unquestionably was due to malignant glands. I did a removal of the pectoral muscles and dissection of the axilla at that time. The glands were involved. She recovered from the operation—lived 2 years and died from a cerebral hemorrhage.

I do not know that a radical operation at the first would have prolonged her life since she died from a cerebral hemorrhage, but I am confident that it could have been done more favorably and should have been done at the first operation. I believe that perhaps we should not be so dismayed by the hypertensive state when we are dealing with malignancy.

These three cases, done in the routine manner, serve to emphasize that modern radical surgical operations on the breast do give eminently satisfactory cures in a high percentage of cases, but that is not to say that the horizon of surgery should not be extended or that we should ignore any effort towards more radical surgery which is within reason and which preserves a functional state. Recently from an Academic Center has come a suggestion that it should be routine to remove the glands along the internal mammary vessels, to invade the mediastinum, to do a dissection of the supraclavicular triangles of the neck on the affected side, and at times to remove the contralateral

breast. That this formidable program must be accompanied by an increased surgical mortality and can only be performed by skillful, tireless surgeons seem to me obvious. I question its availability to the Profession outside of Academic Centers until it has proved that a larger number of 5 year cures can be accomplished with a reasonable, even with a slight elevation of mortality.

It is entirely possible, in fact it is almost an assured fact, that the rate of growth of the tumor, therefore its grading, is probably the most important factor influencing survival rate and recently Park and Lees have flatly questioned the efficacy of treatment in reducing the incidence of death from metastases in cancer of the breast. Nevertheless, this thesis will require serious scrutiny and I think that in the light of results from our present therapy method proof will rest heavily in favor of continued surgical maneuvers.

The next group of cases were operated upon for carcinoma of the stomach after the conventional method of sub-total gastrectomy which has been extended more and more in recent years and unquestionably with satisfaction. The modern trend now is to emphasize total gastrectomy as the method of choice for removal of selected cases of carcinoma of the stomach. A great many of its advocates have overlooked the fact that it is not being used in large Centers as a routine operation, but rather in a selected and carefully controlled group of cases.

CASE No. 4—Mr. A. L. Age 63, 13 Yrs. P. O. L&W-76.

Diag. Cancer of stomach

Oper: Resection of stomach 4-22-38

Path: Anaplastic carcinoma of stomach & local metastases.

This man had a resection of his stomach at the age of 63 and the Pathologist found local metastases in the glands around the pylorus. Nevertheless he lived comfortably 13 years, is now 76 years of age and when seen a few months ago was in good health and without any demonstrative metastases.

CASE No. 5—Mr. H. E. Age 56, 17 Yrs. P. O. L&W-73.

Date of Op: 8-27-34—Cancer of pylorus.

Oper: Resection of $\frac{1}{2}$ of stomach c/ polya anastomosis.

Rem: No glands along greater curvature or in subpyloric group which

were found to be invaded c/ cancer.

Path: Anaplastic ca. of stomach gr. 2.

This man operated upon 17 years ago at the age of 56 had no demonstrational metastases in the removed specimen and has continued well and healthy up until the present time. He is now 73 years of age and when examined recently no evidence of malignancy was found.

CASE No. 6—Mr. T. D. U. Age 68

Diag: Ca. stomach

Oper: Resection $\frac{3}{4}$ of stomach April 10, 1940.

Path: 2 carcinomas of stomach c/ metastases to omentum.

Died: 1950—10 Yrs. P. O.

The interesting point about this man is that he not only had metastases into the glands of the greater omentum, but that apparently, although I resected $\frac{3}{4}$ of his stomach, I must have come practically to the very margin of the tumor for tumor cells were found right up to my line of transection in the specimen. Nevertheless he lived 10 years, although he died of cancer finally. His return of cancer was not in the stump of the stomach, but into his liver and elsewhere throughout his abdomen as demonstrated by autopsy.

One must admit that end results from resection of the stomach by the ordinary sub-total methods have proven unsatisfactory when compared to end results of cancer elsewhere in the gastro-intestinal tract. The operability rate is low and the salvage is low—from 5 to 10% of the whole group of cases living over a period of 5 years. In especially selected cases of low grade cancers and without demonstrational metastases the survival rate is 25 to 30% or even higher. Such statistical data are sufficient reason for urging extension of the operation as widely as possible and it is routine now, I think, for practically all surgeons to remove the greater omentum, to attempt a removal of all the sub-pyloric group of glands and the glands around the coeliac axis, to remove the spleen, if necessary, and to go as high as possible on the lesser curvature of the stomach. This type of subtotal gastrectomy is a formidable procedure in itself, but to remove the entire stomach is a more formidable operation and accompanied by a considerably higher mortality even in experienced and skilled hands.

A group of 139 cases of total gastrectomies from the Lahey Clinic showed a mortality of 34.6% in the first 50 cases

subsequently reduced to 9.4% in the remainder of the series.

Mortality however can be reduced and has been, yet patients having undergone a total gastrectomy have nutritional problems which are enormously difficult to overcome. They suffer an anemia in addition, which is not simple to combat, and a large percentage of them are incapacitated for reasonable occupational effort.

I have no doubt that there are many cases where the operation of total gastrectomy may be indicated. I believe that it fails to remove all the gland bearing areas; namely: around the pancreas and up into the mediastinum, but I do not believe that at the present time it is the type of operation to be used routinely. Certainly it will require a larger group of cases than is at present available for analysis and it unquestionably must be tried out over a period of years to prove that the survival rates have been greatly, or even appreciably increased.

There should be small dissention from the postulate that the poor results following present-day surgery for malignancy of the stomach justifies an extension of effort with a wider removal of contiguous tissues and the growth; however, the experiences of mature surgeons in fairly large series of cases make it plain that this is not a procedure to be undertaken lightly, nor is it likely to become routine for the average surgeon until more definite conclusions as to its utility have been reached. One cannot escape the fact that total gastrectomy is followed by hematologic complications, the most common of which is early post operative manifestations of hypochromic state due to an iron deficiency and frequently later followed by a macrocytic megaloblastic type of anemia. Nutritional changes demand constant effort to maintain a reasonable state of nutrition and the end results, so far as longevity is concerned, remain still unknown. Furthermore the mortality, while it has been reduced to around 10%, is still considerably higher than that of subtotal gastrectomy. As Lahey suggests, great discrimination is necessary in the selection of cases for total gastrectomy and as he so aptly puts it, "The surgeon who undertakes a total gastrectomy must carefully weigh some of the following factors before proceeding with it; his technical skill and surgical experience, the quality and character of the anesthesia, the capacity of the patient to endure

such a long and trying operation and the surgeon and his associates' ability to deal with the changes in conditions which will inevitably be associated with such extensive operations."

Obviously the surgeon who first urged this widening of the base of operation did not mean its indiscriminate employment, but rather its use in a judicious manner in a carefully selected group of cases.

It is to be greatly desired that total gastrectomy in properly selected cases and done with a reasonable mortality will improve a lamentably poor survival rate from one of the most frequently encountered cancers.

This last short series of cases of cancer of the rectum and colon presents a number of interesting factors relative to choice of operation and particularly to the development of metachronous cancers; buttressing, I think, the thesis that polyps are the fore-runners of cancers in a large percentage of cases in the lower g. i. tract and secondly: that an individual who has one cancer, far from being immune from the development of a second one is more likely to develop cancer again.

CASE No. 7—Mr. W. O. B. Age 65, 10 Yrs. P. O. L&W-75

Diag: Carcinoma of sigmoid & diverticulitis.

Oper: Exteriorization of sigmoid—Jan. 6, 1941.

Path: Proliferating diverticulitis of sigmoid. Papilliferous adenocarcinoma of sigmoid grade 2. No glandular involvement.

The case of this sixty-five year-old man who had a carcinoma of his sigmoid and in addition had considerable diverticulitis of the sigmoid is interesting, and moreover the type of procedure shown in his case is interesting and I believe was the operation of choice. He has now lived 10 years and is alive and well without any evidence of recurrence at this time. I chose to do an exteriorization procedure of the so-called Mikulitz type which should be called the Paul-Block Mikulitz operation, for the reason that I felt any extension of operative procedure would be unwarranted because of his poor general condition. His stormy convalescence from even this relatively simple technical operation seemed to bear out that decision. I have not done another Paul-Block Mikulitz operation since that

time and I am conscious that the procedure has been abandoned by most surgeons. Nevertheless in the past it proved a most useful technical maneuver and was a factor in lowering the mortality enormously during the period when decompression, cleansing and finally sterilization of the bowel were becoming recognized as prime factors in successful colon surgery. I question very much if there will be a revival of popularity of this procedure, but one must not forget its satisfactory application 25 years ago when mortality following resection of the colon was around 40% instead of the 2% or 3% which is now more or less routine.

CASE No. 8—Mr. P. M. B. S. Age 47, 20 Yrs. P. O. L&W-67

1st Op. Combined abdomino-perineal resection 1931—ca/rectum gr. 2. No metastases.

2nd Oper. Ca/rt. colon 9-30-46. Resection c/side-to-side anastomosis.

Path: Large adenocarcinoma of cecum at junction of colon. No glandular involvement.

This case is one of a series of cases which I have operated upon in which another carcinoma developed in another segment of the lower g. i. tract many years following the initial resection. This patient had a combined abdomino-perineal resection done in 1931 for a carcinoma of the rectum without demonstrational metastases. His health was satisfactory in the interim between this procedure and the second operation done in 1946 for a carcinoma of his right colon. That 15 year interval is interesting as is the fact that he developed a different type of tumor in the right colon than in the rectum. He survived both procedures and is alive and well today—20 years post operative.

I have recently reported seven (7) cases of metachronous cancers of the colon in which the second cancer developed from two to eighteen years following the first one.

Metachronous cancers of the lower bowel have been reported occasionally in the Literature and Berson and Berger in 1945 collected sixty-six (66) cases of two cancers and six cases with three cancers of the lower intestine to which group they added thirteen cases of two cancers and three cases of malignant growths of the colon, of their own.

Synchronous cancers as contrasted with metachronous cancers have been relative-

ly common, particularly in that group of cases termed "familial polyposis" and one is inclined to believe that occasionally synchronous cancers may be overlooked. Warren estimates the incidence of multiple primary malignancies as high as 6%. This seems a very high figure, and with all the present day facilities for accurate preoperative diagnosis I think the multiple lesions should rarely, if ever, be overlooked.

CASE No. 9—Mr. W. B. Age 38, 10 Yrs. P. O. L&W-48

Date of Op: Dec. 16, 1940.

Diag: Cancer of rectosigmoid.

Oper: Combined abdomino-perineal resection.

Path: Adenocarcinoma of rectosigmoid, gr. 3. No metastases.

2nd Op: 9-12-49. 9 Yrs. later. Resection of descending colon for cancer 4" from colostomy.

This 38-year-old man had an abdomino-perineal resection of the rectum, as you see, for cancer in December of 1940. Although the grade was high there were no metastases demonstrated and he lived comfortably and without symptoms until 1949; a period of nine years exactly, when he developed a carcinoma in his descending colon 4" above his colostomy. That would put the second carcinoma sixteen to twenty inches above the original one. For this tumor a segmental resection with reestablishment of the colostomy was done and at the present time he is alive and well without evidence of recurrence.

CASE No. 10—Mr. F. S. Age 63, 10 Yrs. P. O. L&W-73

Diag: Ca/rectum gr. 2.

Op: Colostomy & posterior resection 11-30-40.

2nd Op: Dec. 15, 1950—Age 73. Segmental resection of the lower sigmoid.

Diag: Carcinoma w/ blind loop of lower sigmoid.

Path: Adenocarcinoma gr. 2 s/ metastases.

This 63-year-old man, 10 Yrs. post operative from a resection of his rectum returned with a second carcinoma at the age of 73. I present this case particularly to demonstrate a fact which I think is sometimes being overlooked; namely: that no one operation is sufficient for handling all carcinomas of the rectum. This man, although only 63 years of age,

seemed to me to be a poor physical risk because of his general flaccidity and co-existing diabetes; therefore, I did a Mummery operation on him—that is a colostomy and posterior resection leaving intraperitoneal a blind loop of bowel. It was in this blind loop of bowel that he developed a second carcinoma. I resected the blind loop and also resected a portion of his descending colon thus completing a radical combined abdomino-perineal procedure. It is less than a year since this was done, but he is healthy and well at the present time. I feel definitely that the choice of operation was a good one and I again emphasize that multiple procedures must be employed for the extirpation of malignancy—be it in the upper or lower g. i. tract.

CASE No. 11—Mr. H. T. L. Age 42, 18 Yrs. P. O. L&W-60

Op: 10-3-33 Ca/rectum gr. 2.

2nd Op: 4-30-48 Resection of 12-18" of bowel for large prolapse & polyps.

3rd Op: 1-21-49 Subtotal colectomy for polyposis.

Path: Multiple ca. in rt. colon and cecum, gr. 2 with local metastases.

This 40-year-old white man operated upon in 1937 for carcinoma of the rectum. Fifteen years later, although we had followed him consistently, we had not made x-rays of his colon routinely and he appeared with a prolapse of his bowel at the colostomy opening and the mucous membrane of the prolapsed bowel was studded with polyps. A resection was done and the colostomy reestablished. The rest of the colon was judged to be clear of polyps, but nine months later he came back with a large number of polyps which had evidently developed rapidly in his right colon, or had been overlooked, and the remainder of his bowel was taken out leaving him with an ileostomy. In the resected specimen there were three carcinomas demonstrated in polyps and I have no doubt had the Pathologist continued his search avidly many more would have been discovered. This was eighteen years post operative and during this time he had been in good health.

I think that this case demonstrates very specifically that the post operative follow-up of cases of cancer of the colon and rectum should include x-ray of the colon at yearly intervals and perhaps at six months intervals and that the colostomy

stoma should always be proctoscoped if at all possible.

CASE No. 12—Mrs. A. C. W. Age 49, 16 Yrs. P. O. L&W-65

Op: Combined A-P Resection 3-9-35.

Path: Adenocarcinoma of rectosigmoid, gr. 4. No glandular involvement.

2nd Op: 4-18-51, 16 Yrs. later. Partial colectomy for ca. of lt. colon.

Path: Adenocarcinoma of colon, gr. 2. No metastases. Benign polyp of colon.

This woman had a combined abdomino-perineal resection of her rectum in March of 1935. It was a high grade growth with the Pathologist classifying it grade 4, but he was unable to find any glandular involvement which is a somewhat paradoxical situation. I think David and Gilcrist have demonstrated to us very forcefully that the more glands one examines, the more likelihood there is of finding invasion and I think it would be a splendid thing for all Pathologists examining specimens of the rectum and colon to utilize the Gilcrist-David Method. It gives us a much more accurate index of prognosis.

This woman returned for her second operation 4-18-51—that is sixteen years after the initial resection of her rectum. A segmental resection of the left colon was done and a new colostomy higher up established. The specimen showed adenocarcinoma, grade 2 and there were multiple benign polyps around the lesion. The balance of her colon however did not show any polyps.

Here again we have a case very similar to the preceding one which seems to add further evidence of the thesis that polyps are the fore-runner of cancer of the colon and rectum in a very high percentage of cases. Indeed this thesis has been belabored so much in recent years that one would think it had only recently been discovered, yet it goes back to the previous century when Schmeiden, Westhaus and others advocated it and numerous Continental and American surgeons and Pathologists have concurred in this opinion over a long period of time. One emphasizes again the malignant potential of a polyp in the lower g. i. tract. Regardless of their size they are not to be taken lightly and once discovered they should serve as sentinels warning us that multiple and frequent examinations of the lower bowel are essential to discover any developments indicating cancer.

Historically it is of interest that Billroth made the first report of multiple carcinomas in 1889 and he set forth postulates which would identify them as independent growths. The postulates were as follows: (1) The two growths should differ histologically; (2) Each growth must spring from its parent epithelium, and (3) Each growth must be regarded as responsible for its own group of metastases. Such postulates cannot be fulfilled in a living patient with two carcinomas in the large bowel, neither of which has metastasized, and Bunting pointed out that these postulates could only apply to malignant tumors arising in different organs. Warren and Gates very aptly broadened the original postulates in 1932 as follows: "Each of the tumors must present a definite picture of malignancy, each must be distinct, and the possibility of one being a metastasis of the other must be excluded." A fourth postulate was added by Mercanton in 1893 who believed that "if, after removal of the two carcinomas, the patient remains free from the disease, the two growths must have been independent else there should have been other metastases." Naturally this implies that a considerable length of time elapse between the discovery of the two growths.

When one considers that about 15% of persons over 40 years of age have polyps

of the colon and that $\frac{3}{4}$ of the polyps are located in the sigmoid and rectum, one must admit further evidence favorable to the thesis that polyp of the lower gastrointestinal tract is a pre-cancerous lesion and should be destroyed on discovery. Some observers go so far as to assert that all polyps of the colon, either are carcinomas or will become carcinomas if they are not destroyed or if the patient lives long enough. This is a dogmatic statement, but one which I find not too difficult to concur in.

With modern methods of diagnosis by Proctoscopy and Radiology and with the recognition of certain basic principles; chief of which is the necessity of decompression of the bowel before any operative maneuver is instituted, it is not surprising that mortality and morbidity statistics have been revised downward hugely.

I believe that the great improvement in anesthesia, the prolongation of the initial preparation period, the use of blood and other agents in the establishment of physiologic equilibrium, plus the use of antibiotics of various kinds in the sterilization of the lower gastro-intestinal tract have forwarded technical procedures to a point where they may be extended even farther and farther in the firm belief that final end results following surgery will be improved proportionally.

Ankle Injuries

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The talus, the tibia and the fibula form perhaps the most frequently injured joint in the body. Major or minor, injuries of this joint may be manifest solely in bone, in ligament, or in a combination of the two tissues.

The problems are:

- (1) To restore the normal weight bearing relationship between the tibia and talus.
- (2) To provide for close proximity of the torn segments of ligament.
- (3) To reduce malleolar fragments with an accuracy proportionate to their size, perfect reduction being the requisite for a fragment composed of an entire malleolus.
- (4) To maintain the parts in their corrected relationship until healing can occur.

An understanding of the mechanism of production is essential to effective management of these injuries. A close relationship exists between ankle injuries manifest in ligament and those manifest in mechanically related bone structure. Study of the anatomy of the joint and of experimentally produced injuries of the ligaments sheds considerable light on the mechanism of these lesions.

The ankle is stabilized in the front primarily by the tibialis anterior and by the long extensors of the toes. The retinaculum for these tendons is an important part of the stabilizing mechanism for the front of the joint. On the lateral side, primary stability is afforded by the peroneus longus, one of the everters of the foot and the peroneus brevis which inserts on the base of the 5th metatarsal and with the peroneus longus passes behind the lateral malleolus. Posteriorly primary stability and plantar flexion are provided by the tendo achillis. On the medial side stability and inversion are supplied by the tibialis posterior. Inert stability on the lateral side is supplied by the fibular collateral ligament, the anterior talofibular component of which tightens on plantar flexion and inversion and loosens on dorsiflexion. By reflecting the peroneal ten-

dons anteriorly, the fibulo-calcaneal element of the lateral ligaments stand out.

The fibulo-calcaneal ligament tightens on dorsiflexion and inversion. The posterior talofibular ligament tightens on dorsiflexion and on external rotation and is loose in internal rotation. Viewed from behind, the fibulocalcaneal element of the intact fibular collateral ligament stands out clearly, and on forced inversion of the foot we see that the talus does not tilt. On plantar and dorsiflexion the distance between the talus and tibia is uniform all the way across the joint. Coursing obliquely upward and medially from fibula to tibia, we see the anterior leaf of the tibiofibular portion of the interosseous ligaments.

On the medial side we see a superficial portion of the deltoid ligament prolonged anteriorly and laterally. When the tibialis posterior is removed from its sheath more of the superficial portion of the deltoid ligament is shown through the floor of that sheath.

Intact interosseous ligaments aid in resisting an attempt to produce lateral shift of the talus on the tibia.

When the bony tip of the lateral malleolus giving attachment to the fibular collateral ligaments is divided, complete dislocation of the talus from the ankle mortice can be effected. Attention is invited to the fact that this takes place readily when the interosseous ligaments are completely intact.

Now if the fibular collateral ligament be reconstituted, it is again impossible to dislocate the talus from the ankle mortice. Following division of the interosseous ligaments, an attempt to displace the talus laterally on the tibia meets with no success. As a result of this lesion which is readily produced experimentally but not encountered clinically, the mobility of the fibula is increased markedly.

When to the foregoing experimental lesion we add division of the deltoid ligament, the talus can, of course, readily be displaced lateralward in the ankle mortice. This represents the clinical condition referred to as "spread mortice," a condition which depends on coexisting damage to deltoid and interosseous liga-

ments. Now if the interosseous ligament alone is artificially reconstituted by passing a wire loop through drill holes, and the deltoid ligament is allowed to remain severed, again it is impossible in spite of strong pressure to produce a lateral shift of the talus on the tibia. Once more then, let us emphasize that for spread mortice to occur there must be coexisting damage to the interosseous and deltoid ligaments or their bony counterparts.

With all ligaments of the joint severed, of course, marked instability appears.

Inversion and Eversion Injuries

The common ankle injuries derive from one of the basic foot motions—i. e., inversion or eversion (Fig. 1). Significant injuries disrupt either ligament or bone, or a combination of the two.

Inversion injuries (Fig. 2) threaten the fibular collateral ligament as we have seen, or the lateral malleolus. When it is this bony structure which gives, the fracture line is transverse. In either case, residual unspent force may be dissipated in vertical fracture of the medial malleolus without or with displacement.

Eversion injuries (Fig. 3) may, as we have seen, disrupt only ligamental structures. These structures are separate and distinct from those threatened by inversion injuries. Each ligamental injury has its bony counterpart. Commonly a given injury presents a mixture of bony and ligamental elements. Though closely neighboring regions are involved, the pattern of bony injury by eversion as it involves the malleoli is distinct from that by inversion. In fact there is a roughly reciprocal relation of the pattern of the two categories of injury as manifest in the malleolar fracture. Although the point has not been firmly established, it is dif-

ficult to conceive of how significant eversion injury can appear without concurrent injury to the deltoid ligament or its bony counterpart and to the interosseous ligaments or their bony counterpart.

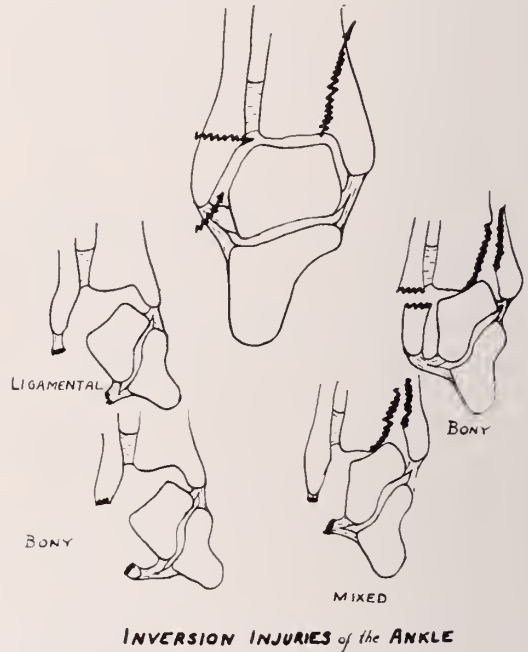


Fig. 2. INVERSION INJURIES. When bone is involved, the fracture line is vertical and high in the medial malleolus and horizontal and low in the lateral malleolus.

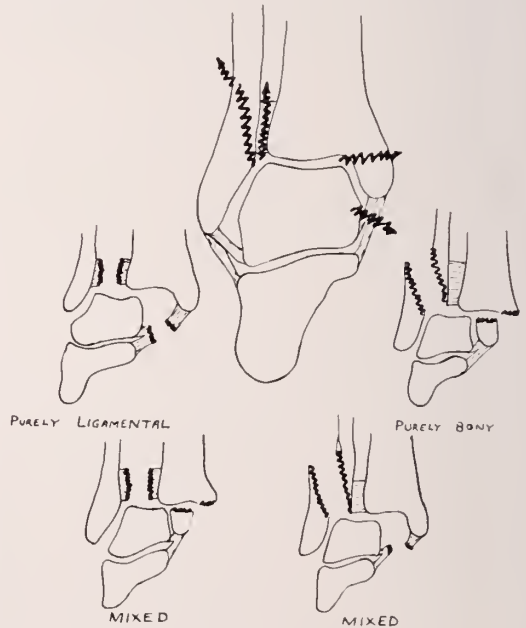


Fig. 3. EVERSION INJURIES. When bone is involved, the fracture line is transverse and low in the medial malleolus and oblique and high in the lateral malleolus.



Fig. 1. The normal foot positions from which the major categories of ankle injuries derive: INVERSION (a); EVERSION (b)

These basic patterns of ankle injury are modified by a number of factors:

- (1) The magnitude of the rotational factor.
- (2) Degree of plantar or dorsiflexion during application of the damaging force.
- (3) Amount of compression accompanying the injury, that is the amount of weight being thrust through the joint.
- (4) Magnitude of the force tending to displace the foot backward on the tibia.
- (5) Exact position of forefoot at time of fracture.

Because of the greater elasticity of the

foot in inversion, there is much less of a rotational factor than in the usual injury due to eversion. Most classifications of ankle injuries thus include as separate headings abduction and external rotation. Both are elements in the normal motion of eversion. These same classifications on the other hand employ only one heading for injuries in the opposite direction designating them either as adduction or as inversion injuries, terms used interchangeably by different writers.

Clinical Differentiation of Inversion and Eversion Injuries

Where a fracture line is shown in the x-ray, there is little or no difficulty in differentiating these two groups of injuries (Fig. 4a) (Fig. 5a,b). Where no fracture line is seen, the importance of differentiating the causative mechanisms has great bearing on steps taken in management of the patient.

We may be fortunate enough to be dealing with an emotionally stable, observant patient who can assure us that the injuring mechanism was clearly one or the other. In such circumstances great reliance can be placed on the evidence presented by the patient. Where, for any reason, the patient is unreliable, clinical observation is of increasing importance.

The inversion injury without fracture shows clinically greater swelling laterally than medially or anterolaterally. This is confirmed by soft tissue shadows in the x-ray which can be observed best in the bright light of a goose-neck lamp (Fig. 6). Tenderness is most marked laterally and particularly just in front of the tip of the fibula over the location of the anterior talofibular ligament. There may



Fig. 4. INVERSION INJURY. In "a" is shown a fairly typical inversion injury. In "b" we see the inadvisability of the obliquely placed screw in an inversion injury. There has been loss of bone substance by comminution and compression. When the malleolus was compressed against the tibia to close up the ensuing gap, the deltoid ligament pulled the talus into an unfavorable weight bearing position.



Fig. 5. EVERSION INJURY. Here we see the eversion mechanism manifest principally in bone damage. There has been attendant backward thrust of the foot of the tibia. Position was readily restored by proper reduction maneuvers and maintained by plaster fixation.



Fig. 6. Localization of swelling as shown in soft tissue shadows on the radiograph. The inversion injury "a" shows maximum swelling over the lateral malleolus and little or none over the medial side of the joint. The eversion injury "b" shows swelling over both sides of the joint. That over the medial side is deserving of emphasis.

be tenderness over the anterior aspect of the joint especially where considerable swelling exists, due to distension of the joint by hematoma. Lateral tenderness as described considerably overshadows medial tenderness and tenderness present over the interosseus ligaments.

Where an eversion injury exists, medial swelling is marked, and while swelling due to damage to the interosseous ligaments may be present, anterior tibiofibular ligament tenderness is likely to be a feature. Occasionally by good fortune, the film may show increased distance between the medial malleolus and the talus. A high fracture of the fibula is often present which may escape inclusion on the film.

We may be able to demonstrate increased mobility to ordinary clinical examination in the case of the inversion injury in the direction of inversion talar tilt, and in the case of the eversion injury in the direction of direct lateral displacement of the talus on the tibia by pressure on the medial aspect of the heel and lateral counter-pressure relatively high on the leg.

If by now positive evidence of serious damage in the direction either of inversion or eversion has not been produced, the possibility of such damage can be excluded only by stress films under adequate anesthesia.

Inversion Injuries

The inversion variety is the common form of ankle injury. It results from what the layman describes as "turning" his ankle. As we have seen, inversion initially jeopardizes merely the fibula and the fibular collateral ligaments. If the injuring force persists, an oblique or vertical line extends upward from the deep aspect of the medial malleolus ultimately mobilizing this structure. When the ligaments alone bear the brunt of the injury, the usual x-ray examination is negative, and the full severity of the injury may not be recognized. Herein lies one of the problems of handling ankle injuries; that is, how one should deal with the situation presenting the possibility of severe injury to the fibular collateral ligaments (Fig. 10). Swelling and external signs of damage may not reflect the severity of the ligamental damage. If strapping or novocain injection are employed alone or in combination, the way will be open for laxity of the lateral ligaments. If one's object

is to prevent this possibility, he must seek exact evidence of the severity of the injury by taking stress films of the ankle under anesthesia. This may be light general anesthesia or good local anesthesia. When the injury exists, plaster immobilization for six or eight weeks is necessary to obtain a perfect result. A perfect result should be sought in a young individual especially if he aspires to a career in athletics. On the other hand there is considerable evidence that many adults, as a result of old inversion ankle injuries, have relaxed lateral ligaments in one or both ankles and suffer little from it in their normal daily activities. In the civilian adult whose routine of life does not demand agility, one is perhaps justified in treating an inversion ligamental injury of the ankle without regard to the possibility of later relaxed lateral ligaments. Where the evidence of severe injury is considerable even in such individuals, it would be wise conservatism to employ plaster immobilization preferably with a walking cast for a period of six to eight weeks. Of course, any immobilization of the lower extremity invites a measure of joint stiffness. Although this stiffness is always temporary, it is well to combat the tendency to it in advance. The lesson of allowing free mobility of the fingers in upper extremity plasters whenever possible has been well learned and widely accepted. The same principle must be transferred to the lower extremity. Immobilized in such a plaster the patient can maintain and actually increase mobility of the toes. As a result of doing so, there will be markedly less stiffening of the tarsal and ankle joint when the plaster is removed.

When the inversion injury includes fracture of the medial malleolus, perfect reduction must be obtained. The reduction maneuver here consists simply of direct pressure over the inner aspect of the heel and the medial malleolus in a lateral direction with counter-pressure in a medial direction over the lateral aspect of the ligament above the ankle. Plaster is put on while these pressures are exerted, and as it sets, molding in the same direction is carried out. It is unnecessary to extend the plaster above the knee. Immobilization should be for a minimum period of ten weeks. If an adequate effort at accomplishing reduction by closed means proves unsuccessful as it frequently will, then open reduction is in order. The screw

should be placed in a transverse rather than in an oblique direction.

In summary, where a perfect result is important, accurate evaluation of the ligamental damage should be obtained by inversion stress films under anesthesia. Where the daily requirements of the patient include no special degree of agility, it is reasonable to overlook the possibility of complete ligamental tear in all patients except those presenting the greatest suggestion of severe injury. For the latter group and for those in which damage has been shown by stress films, plaster immobilization for a period of six or preferably eight weeks is in order. Remaining patients can be treated either by strapping, novocain, bed rest, or any combination of these. As a rule, that form of treatment which provides for maintenance of the highest level of activity beginning promptly after the injury will be attended by the greatest success.

Eversion Injuries

Where the injury has been by eversion, the greatest danger lies in the failure to recognize a severe degree of ligamental damage. In contrast to the situation existing with the inversion mechanism, such a failure where the eversion mechanism is concerned threatens severe disability to



Fig. 7. Eversion injury with disruption of the deltoid and interosseous ligaments. The fibula fracture is above the latter structures. It might be higher and missed by the x-ray film, or the ligaments alone might be injured without accompanying fracture.

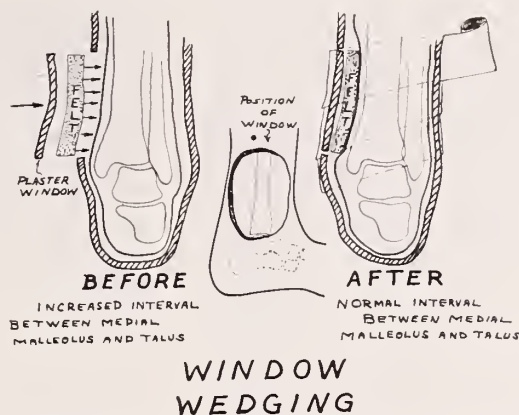


Fig. 8. WINDOW WEDGING. Where there is lateral subluxation of the talus on the tibia. ("spread mortise"), a window can be cut over the lower tibia, a felt pad inserted, and the tibia pushed lateralward. When the plaster window is replaced, and circular turns of new plaster made around it, the corrected relationship is maintained.

everyone regardless of his pattern of living. It should be emphasized again and again that unless sought for, a complete tear by eversion can be overlooked. Herein lies the most important reason for distinguishing between inversion and eversion as the mechanism producing the injury under treatment. As we have seen, it is acceptable practice to overlook complete tears of the lateral ligaments in some instances, but such is not the case with the ligamental injury resulting from eversion, namely combined tears of the deltoid and the interosseous ligaments (Fig. 7). Thus where the mechanism of eversion is apparent or is suspected, one has no alternative but to treat the patient on the assumption that a complete eversion type ligamental injury is present or to demonstrate conclusively its absence by stress films under adequate anesthesia taken with the foot pushed away from the tibia in a lateral direction. Any increase in the distance between the talus and the medial malleolus demonstrated in such films requires that absolute control over the relation between the talus and tibia be gained and maintained. This is done by immobilizing the foot in plaster and obtaining new films to demonstrate the relation of the talus to the tibia. If this is unsatisfactory "window wedging" (Fig. 8) may be tried in an effort to correct the situation. Here a window is cut over the medial aspect of the leg just above the ankle level. The plaster removed is saved and a piece of thick felt of similar size is cut. The felt is inserted into the window. The plaster plug is replaced on top of the felt. Tight turns of plaster

bandage taken over the plaster plug will make pressure on the tibia above the talus and restore its weight bearing relation to that bone. Analgesia by an intravenous opiate is desirable. If this or other efforts at closed means of restoration of the tibiotalar weight bearing relationship are unsuccessful, open reduction is in order. If the medial aspect of the joint is disrupted by injury to the bone rather than injury to the ligament, the important relationship is that of the convex articular surface or plafond of the tibia to the corresponding concave articular surface of the talus. Again the importance of accurate reduction of the medial malleolar fragment in such situations is in direct proportion to its size. The classical reduction maneuvers consist (Fig. 9) first of traction, then while traction is maintained, of internal rotation of the foot about the long axis of the tibia, and finally while still maintaining traction, of pressure on the tibia above the ankle in a lateral direction with counter pressure over the heel below the ankle (Fig. 5). Where there has been posterior displacement of the talus on the tibia, the foot must be pulled anteriorly as the above maneuvers are carried out. If there is also displaced fracture of the posterior lip of the tibia, the foot must be placed in forced dorsiflexion in an effort to restore and maintain this fragment in position. Immobilization must be continued for a period of ten weeks and beyond this pending x-ray evidence of satisfactory healing. Plaster, at first, should go above the knee, but in the final weeks may be changed to a boot cast, and a walking iron may be added. Trimming around the foot should be the same as shown for inversion injuries. In the presence of a sizeable medial malleolar fragment, open reduction and internal fixation is technically easy and has therefore become popular. Where appreciable displacement has existed, of course, this procedure per se does not effect repair of the damage to the interosseous membrane or the lateral malleolus. Because the deltoid ligament remains intact, accurate reduction of a displaced fracture of the medial malleolus does, however, restore the tibiotalar weight bearing relation. Where the eversion injury is purely ligamentous, ("spread mortise"), and plaster proves inadequate, the simplest form of operative repair is gained by merely inserting a screw or a bolt so as to pull the tibia and fibula together tightly. This, of

course, does not accomplish any *direct* repair of the deltoid ligament just as open reduction of the displaced medial malleolus does not per se constitute repair of the torn interosseous structures which, in the absence of fractured lateral malleolus invariably accompany the displaced medial malleolar fracture.

Anterior and Posterior Lip Fractures

Fractures of the anterior and posterior lip may complicate the major categories



Fig. 9. Reduction maneuvers for eversion injury. Traction maintained (a), and while it is maintained, first the foot is internally rotated on the long axis of the tibia (b), and then pushed medialward on the tibia (c). Complete anesthesia is necessary for this and other reduction maneuvers.



Fig. 10. INVERSION INJURY. This purely ligamental inversion injury was not detectable "a" on ordinary radiography. In "b" the effect of inversion is shown, and in "c" it is seen that forced eversion produces no displacement (Courtesy of Dr. Wood W. Lovell).

of ankle injury and are found usually in association with those recognizable as of the eversion variety. Accurate reduction and dependable fixation of anterior lip fractures are a necessity. Fractures of the posterior lip which comprise less than 1/3 of the joint surface in the lateral x-ray view need not be reduced with complete accuracy so long as the accompanying dislocation of the talus is well reduced and maintained. When the fragment comprises more than 1/3 of the joint surface in the lateral view, perfect reduction is necessary. This can sometimes be accomplished by a position of exaggerated dorsiflexion of the foot. When this fails, open reduction is necessary and represents one of the most difficult operations in orthopedic surgery.

Compression Injuries

Compression injuries are prone to produce the most irreparable forms of ankle damage. They are likely to be accompanied by extreme comminution and to defy open reduction to any practical end. They are probably best treated by some form of continuous or fixed traction. Too often this must be regarded merely as a preliminary to ankle fusion, the immediate objective being to prevent healing in excessive deformity.

Indication For Open Reduction

Indications for open reduction are:

- (1) Irreducible or uncontrollable medial malleolar fragments.
- (2) Irreducible or uncontrollable lateral subluxation of the talus ("spread mortice").

- (3) Irreducible or uncontrollable posterior lip fragment comprising more than 1/3 of the joint surface.
- (4) Irreducible or uncontrollable anterior lip fragment.

Contraindications to open reduction:

- (1) Injuries readily reducible and controlled by closed means.
- (2) Comminution of weight bearing surfaces rendering hopeless prognosis for preserving function.
- (3) Patient in poor general condition.
- (4) Local tissues in bad condition, rendering infection likely.

Discussion

If good medical care is to be given patients with the greatest economy to all concerned, it is important that those physicians not specialists handling these injuries have a working knowledge of conditions which at one level of severity they can treat effectively and another level require greater skill. It is with this in view that this paper is written. If the practitioner recognizes when open reduction will likely be necessary, if he does not overlook a severe eversion injury merely because a conventional x-ray does not show it, and if he knows and applies the criteria of satisfactory reduction and maintenance of position in this category of injuries, a great many disabilities will be avoided.

Summary

1. The normal foot motions of inversion and eversion strongly influence the pattern of most ankle injuries.

2. In the absence of x-ray evidence of displaced fracture there is considerable danger of overlooking the true severity of an ankle injury.
3. Failure on the part of the doctor to recognize the full severity of an *inversion* injury invites difficulty *only* in the case of individuals whose routine of life requires agility.
4. On the other hand if the full severity of an eversion injury is not recognized and sufficient support not given during the healing period, serious disability will result.
5. Anatomical reduction of fractures of the weight bearing surface of the tibia is necessary if serious handicap is to be avoided. To accomplish this by open means may test the mettle of the most skilled orthopedic surgeon.

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Diagnosis and Treatment of Aneurysms and Arteriovenous Fistulas

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I am most appreciative of the honor of being asked to speak here. Like all native Kentuckians I am just living away from home, and am happy for the opportunity to return. The subject which I have chosen is not altogether inappropriate since aneurysms are so frequently the result of wounds of conflict, either from declared or undeclared war, and citizens of the "dark and bloody ground" have long been known to settle their differences in their own way, and usually with gun or sword.

An incident of blood vessel injury in the early medical history of Kentucky was the result of a duel fought between two prominent doctors, Benjamin Dudley, Professor of Anatomy and Surgery at Transylvania, and William H. Richardson, Professor of Obstetrics in that institution. The story is recounted by Dr. Robert Peter, historian of that period:

"Richardson was seriously wounded in the groin by a ball of Dudley, severing the inguinal artery. Richardson would have speedily bled to death but for the ready skill and magnanimity of Dudley. He immediately asked permission of his adversary to arrest the hemorrhage, and by pressure with his thumb over the ilium gave time for the application of the ligature by the surgeon of Richardson—thus converting his deadly antagonist into a life-long friend."

The incidence of vascular injuries during World War II was so great that an unprecedented experience in treating vascular damage and its sequelae was recorded. We are at present seeing at Walter Reed General Hospital many injuries of this type from the Korean war. Let me here note that a lesson learned in World War II, and one we cannot afford to forget, was the importance of the specialized centers in establishing for military medicine its greatest record in history. A large measure of our success in treating vascular injuries was due to the

concentration of men who had specialized in this problem.

In civilian practice, vascular injuries are not so frequently seen, and the common sequelae, aneurysms and arteriovenous fistulas, are comparatively rare. The common denominator of these lesions, whether of warfare or civilian life, is the penetrating wound. High explosive shell fragments were the most frequent cause of blood vessel injury during the last war. Taken from the records of civilian patients I have treated, some of the vascular injuries of civilian life resulting in aneurysms have been caused by just such insignificant accidents as these: a board with a nail in it broke when stepped upon and struck the victim on the head, causing an arteriovenous aneurysm of the temporal artery and vein; a fall in which the victim struck his head, suffering a concussion, and which produced a communication between an artery and vein (this is an example of a lesion produced without external wound or penetrating instrument); a knife injury in which a butcher struck his arm against the knife he carried in a pocket to cut string; and another knife injury which occurred during hog-killing time, when a farmer was holding a pig to be stuck but instead was himself stuck in the leg. Glass slivers in automobile accidents account for a number of aneurysms, and surgical procedures produce more arteriovenous communications than we would like to admit. These have been caused by venepuncture, the application of skeletal pins and transfixion sutures, incision of abscesses, and other procedures.

The external injury may be so slight as to be regarded of little importance, but at the same time produce extensive damage to the underlying vessels. It is a well-known fact that a vascular lesion may develop slowly to the point of recognition. Blood vessels are usually accompanied by nerves; and nerve lesions, which are so striking in their immediate manifestations, may mask or cause to be overlooked accompanying blood vessel trauma. Other seemingly more important

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injuries of bone or soft tissue may divert the attention of the examining physician.

Aneurysmal swellings are for the most part due to one of the following: true arterial dilatation; a false aneurysm or pulsating hematoma; or an arteriovenous communication. The first type is seen most often in civilian patients rather than soldiers, since it is due mainly to syphilis of long standing or to arteriosclerosis. A false aneurysm results from partial division of the arterial wall and the formation of a hematoma. If a concomitant wound of the artery and vein occurs, an arteriovenous fistula may result. In the presence of a fistula, the blood is short-circuited from the artery directly to the vein without passing through the capillaries. As the anastomosed vessels enlarge, the opening of the communication may similarly enlarge. Frequently a false aneurysm is found in association with the anastomosis. These false aneurysms do not tend to be as large as in the instances of arterial aneurysms because of the decompression afforded by the vein.

The differentiation of a false arterial aneurysm and an arteriovenous fistula is extremely important, since the sequelae, the general and local effects, and the treatment of the two conditions differ greatly. The differential diagnosis is not always easy, but as a rule the arteriovenous aneurysm is characterized by a *continuous*, vibratory thrill and a loud, rough murmur with systolic intensification, whereas in the false aneurysm, there is a distinct pause between the systolic and diastolic phases, and often the murmur is heard only in systole. In an arteriovenous communication, the murmur is usually transmitted for some distance on either side along the course of the vessels, whereas in an aneurysm confined to an artery, the murmur is rarely heard beyond the confines of the dilatation. In the case of a fistula, the swelling is usually less pronounced, although some fistulas with a false sac may give rise to a tumor of considerable size. The dilatation of cutaneous veins in the region of the fistula and distal to it are further points for differentiation.

Temporary occlusion of the fistula, which may be produced manually or with a blood pressure cuff, results in several circulatory changes, the most common of which is the slowing of the pulse rate, usually referred to as Branham's sign. This has been observed in almost all in-

stances in which compression of the fistula is possible, and has not been observed in patients with simple arterial aneurysm. Hence, it is believed that the slowing of the pulse rate is a valuable diagnostic sign in the differentiation of purely arterial from arteriovenous aneurysms.

Swelling and a pulsating hematoma are the first signs of an arterial aneurysm. Early signs of an arteriovenous aneurysm are variable and depend upon the location and size of the fistula. The patient may notice the presence of a pulsating mass or discover the thrill, or buzzing sensation as patients are apt to describe it, characteristic of the communication. This may be noticed immediately following injury, but frequently is overlooked for years. In other instances it may be found only after careful examination.

Regardless of the site of the lesion, local evidences of a fistula are similar. The most common sign is the bruit, or murmur, which can be heard with a stethoscope in the region of the fistula. The chief cause of failure to hear the murmur is simply failure to listen for it. If the murmur is of sufficient intensity, a thrill may be felt. The thrill is less well transmitted than the murmur and is localized to an area near the lesion.

If the fistula is a large one and in an extremity, the pulse distal to it may become weak or even disappear. The temperature of the extremity distal to the fistula is usually colder than that of the opposite side, and ulceration or other evidences of impaired circulation, even gangrene, may be present. Frequently, patients are erroneously treated for varicose veins and ulcers when an arteriovenous aneurysm is responsible for the condition. A few weeks after the establishment of a communication, the veins in that region will become noticeably enlarged and may even pulsate, and the temperature of the skin in the region of the fistula is usually increased.

There is no condition which produces such an extensive collateral circulation as does the interposition of a fistula between an artery and a vein. However, this circulation is for the most part useless since most of the blood in the collateral vessels passes back through the fistula without reaching the part beyond it. While this circulation is of little value when the fistula is open, it means that the fistula can be eliminated without fear of resulting gangrene, provided sufficient time is al-

lowed for full development of collaterals—usually within three months. Since a considerable portion of the blood passes through the fistula, nutrition of the part will often be improved after removal of the lesion.

As viewed at operation, the proximal artery and vein are usually dilated. The artery distal to the fistula is more frequently small, the size depending on the amount of blood shunted away from it through the fistulous communication. The vein distal to the fistula is usually dilated because of the shunting of arterial blood into it. The collateral branches, both venous and arterial, are increased in size.

The heart usually presents no abnormalities on physical examination; however, in many patients there is an alteration in the size of the heart which can be detected only by the decrease in the transverse diameter as measured by teleroentgenograms before and after operative eradication of the fistula. Occasionally the heart may become considerably enlarged. Since the change is reversible soon after removal of the fistula, it is assumed that the enlargement represents dilatation rather than true hypertrophy, although in patients with fistulas of long standing, irreversible hypertrophy may occur. Frank congestive heart failure may occur either early or late in the course of the condition.

The operative procedures most generally employed in the treatment of these lesions are the Matas endoaneurysmorrhaphy for aneurysms, and quadruple ligation and excision for arteriovenous fistulas. These methods are not used to the exclusion of all others, and in many instances the type of lesion or its location requires the combination of one or more methods. Makeshift or incomplete procedures should be particularly avoided because hemorrhage, recurrence of the lesion, or gangrene are likely to follow.

The Matas principle of intrasaccular suture is believed to be the best method yet devised to cure an aneurysm and at the same time preserve the maximum amount of collateral circulation. It is usually performed where the aneurysm is large, and where dissection of the aneurysm, even if possible, might result in damage to surrounding structures. It is difficult to employ in small aneurysms accompanied by damage to nerves, a not infrequent occurrence. In these instances it is possible to excise the aneurysm after ligating the ar-

tery proximal and distal to it, and perform nerve suture or neurolysis at the same time.

In the treatment of arteriovenous fistulas, one of two procedures is most generally employed: first, some type of operation whereby the communication between the artery and vein is obliterated by suture; or secondly, ligation of the vessels leading to and from the fistula and complete extirpation of the fistula. This latter procedure, quadruple ligation and division, is done, of necessity, in the large majority of cases. Certainly it is preferable, where possible, to preserve the artery; but from a practical standpoint this is difficult to accomplish since the vessels at the site of the lesion are frequently embedded in scar tissue which prevents accurate dissection of the communication. Moreover, the fistulous opening may be so large that its closure necessitates occlusion of the vessel. Likewise, the presence of a false sac directly communicating with artery or vein or interposed between the two vessels may prevent proper closure of the fistula and maintenance of the arterial lumen.

Where actual repair is possible, it is necessary to isolate completely, and temporarily occlude, all vessels communicating with the fistula. Usually the vein must be sacrificed and separated from the artery as a preliminary step in closing the opening. Occasionally the opening may be closed by transvenous sutures. It must be borne in mind that while operative repair is ideal in preserving the continuity of the artery, it is not without danger. Secondary hemorrhage, thrombosis and recurrence are more apt to follow this procedure than where the fistula is excised. Mere ligation of major vessels will not cure the lesion and more often leads to gangrene of the limb.

As indicated previously, many variations of these operative procedures are necessary because of differences in the structure of the aneurysms and fistulas and because of their anatomical location. Approaches should be planned with isolation and control of the vessels as the primary objective, a factor usually of far more importance than the surgical attack on the lesion itself. Unless such a plan becomes an integral part of every procedure, hemorrhage may result in a fatality or so interfere with the operation that its successful accomplishment becomes impossible. If the first consideration in plan-

ning the operative treatment of aneurysms and arteriovenous fistulas is the exposure and control of major vascular trunks, the hazards of the operation will be greatly reduced.

In operations for treatment of aneurysms at the base of the neck, the clavicle may require resection in order to secure proper exposure. Similarly, a portion of the fibula, including its head, must be resected in order to properly expose the tibial and peroneal vessels in the upper portion of the leg. These bone resections are carried out subperiosteally. There is no necessity of replacing the bone since in these locations stability is maintained and the bone usually regenerates.

Care must be exercised in the placing of skin incisions so as to minimize contraction by scar. They should never cross skin folds perpendicularly. This is par-

ticularly important in the popliteal and cubital spaces, where the incisions should be S or Z-shaped, so that one limb of the incision crosses the space transversely. Otherwise, contracting keloids are almost certain to form. Wherever possible, an incision should not be made on the sole of the foot since it is invariably painful on weightbearing.

The anesthetic of choice for operations upon the lower extremities is continuous spinal; for operations upon other parts of the body, pentothal sodium supplemented by nitrous oxide and oxygen. In operations on the neck, the introduction of an intratracheal tube insures an open airway and a smoother anesthetic. The great majority of these operations require an average of three hours, although they may require as many as seven hours.

Torular Meningo-Encephalitis

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Torula invasion of the central nervous system is a relatively uncommon occurrence if its incidence is to be based on fully verified recorded cases. Only two such instances have been encountered at St. Joseph Infirmary; and a survey of the literature discloses that only about two hundred and thirty cases of human torula infection have been reported since this entity was first described some fifty years ago. Torula almost invariably invades the central nervous system, but the total number of cases of torulosis is somewhat higher than those with meningo-encephalitis. Of a total of 220 reported cases recently reviewed, 81% exhibited central nervous system involvement¹. Only 12 instances in which either the spinal cord or its membranes showed involvement of Torula have been reported¹¹.

Although acute forms of the disease have been known, typically human Torula infections are of a chronic nature and most commonly implicate the central nervous system and lungs. Isolated instances of recovery have been cited¹⁵, but death is the expected termination of the disease. Very few diagnoses have been made before death.

The purposes of this report are several: to record two additional cases, one being

recognized before death, and the other still living; to call attention to the various methods which can be used in the diagnosis; and finally to express the view that human torulosis may not be as rare a clinical problem as has been heretofore believed.

Case Reports *

CASE 1. 51-1723-W. B.: A sixty-five year old man was admitted to St. Joseph Infirmary on February 8, 1951. Because of the patient's confusion, only a fragmentary history could be obtained. Two months prior to his admission he began to suffer with generalized headaches which became progressively more severe. These headaches were occasionally associated with nausea and vomiting. Shortly thereafter he had anorexia and progressive weakness. At times he was mentally confused and his speech was incoherent. For many years he had used alcohol to excess and had been treated for cirrhosis of the liver, kidney disease and hypertension.

EXAMINATION: The patient appeared drowsy and gave the impression of being seriously ill. The systolic blood pressure was 170 mm. of mercury and the diastolic pressure was 90 mm. There was a sug-

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gestion of lower facial weakness on the right side. The oral temperature was 99.8 F. There was no stiffness of the neck. Laboratory studies revealed the following findings: Roentgenograms of the chest and skull were within normal limits. The concentration of hemoglobin was 15.3 gm. per 100 cc of blood. There were 5,240,000 erythrocytes and 6,550 leukocytes per cubic millimeter of blood. The sedimentation rate was 11 mm. per hour. Urine negative. Lumbar puncture revealed the cerebrospinal fluid to be slightly xanthochromic and the pressure to be 200 mm. of water. The fluid contained 150 cells per cu. mm. composed of 54% polymorphonuclear leucocytes and 42% lymphocytes. The total protein was 350 mg. per cent and the sugar was 18 mg. per cent. The Wasserman was negative and the colloidal gold curve was 0011443221. A Gram stain of the fluid revealed yeast-like fungi resembling *Torula histolytica* and a culture of the fluid produced a definite growth of *Torula histolytica* two days later.

Course of the Disease

The patient was given 400,000 units of penicillin twice daily intramuscularly and was placed on a high protein diet which was supplemented with large amounts of vitamins particularly vitamin B. The lumbar puncture was repeated on the second day following admission to the hospital. The spinal fluid was slightly xanthochromic. The spinal fluid pressure was 150 mm. of water and it contained 58 cells, 93% of which were lymphocytes and 7% were polymorphonuclear leucocytes. A primary smear of the fluid again revealed *Torula histolytica* and the culture produced the same organism five days later. 20,000 units of crystalline penicillin was instilled into the spinal subarachnoid space at the time of this second lumbar puncture. During his hospital stay the patient continued to complain of headache. On two occasions he had moderately severe clonic movements which were limited to the lower extremities. These movements occurred shortly after the intrathecal penicillin was given. For the most part he was involuntary of urine and feces but he also had to be catheterized on three or four occasions because of urinary retention. A lumbar puncture done on February 13 revealed 391 cells with 89% lymphocytes and 11% polymorphonuclear leucocytes. On February 14 his rectal temperature rose to 103.2 F. but

gradually returned to normal within the next twenty-four hours. At this time his non-protein-nitrogen was 62 mg. per cent. On February 16 the patient was transferred by ambulance back to the hospital in his home town where treatment was continued by his local physician. Intrathecal penicillin was given every other day for a month and 250 mgm. of chloromycetin was given every six hours for the same length of time. At the time of this writing, one year later, this man is able to be up and about. However, he is mentally disturbed and unable to care for himself.

Second Case Report

CASE 2, S-3931-L. A. W.: A 30-year old girl was admitted to St. Joseph Infirmary on July 20, 1951 because of severe headaches of about six weeks duration. During the first week of June she received a smallpox vaccination plus other injections prior to going to Mexico City for a vacation. At approximately this time she began to suffer with bifrontal headaches, but they did not prevent her from going to Mexico. She returned from her trip about two weeks prior to her admission to the hospital and at that time was beginning to have severe generalized headaches which did not respond to the usual analgesics. She did not have any chills or fever. Two days prior to admission the headaches became so intense that she was unable to sleep even with sedatives. It was learned that one of her best friends had recently been treated in Waverly Hills Tuberculous Clinic.

Examination

There was slight limitation in flexion of the head on the thorax and questionable papilledema of the left optic disc. Roentgenograms of the paranasal sinuses showed marked cloudiness in the right maxillary antrum and anterior ethmoid cells. Roentgenograms of the skull, chest and entire spine did not disclose any abnormality. The urine, blood counts, flocculation tests of the serum for syphilis and heterophil antibody test were all negative. The blood sedimentation rate was 15 mm. per hour. Lumbar puncture revealed the cerebrospinal fluid pressure to be 400 mm. of water. Chemical analysis of the fluid showed 53 mg. of protein, 58 mg. of sugar and 706 mg. of chlorides per 100 cc. The cell count was 104 cells with 75% lymphocytes and 25% polymorphonuclear leucocytes. A culture of the fluid showed no growth after one week.

Course of Disease

Two days after admission, the patient developed a bilateral sixth nerve paralysis. A lumbar puncture at this time revealed essentially no change in the cerebrospinal fluid pressure. Chemical analysis showed 40 mg. of protein, 40 mg. of sugar and 692 mg. of chloride per 100 cc. The cell count was 90 with 67% lymphocytes and 33% polymorphonuclear leukocytes. In view of the history of vaccination, a diagnosis of post-vaccinal meningoencephalitis was entertained at this time although the possibility of a chronic meningitis due to an organism such as the tubercle bacillus was considered. The headaches remained severe and required demerol for partial control. Other symptomatic measures, including a blood transfusion and terramycin 500 mgm. every six hours were carried out. On July 30, the patient's condition suddenly became much worse. She developed a bilateral papilledema, a complete facial nerve paralysis on the left in addition to the bilateral sixth nerve paralysis, and a right hemiparesis. She became disoriented and irrational and required large doses of sodium amytal to control her restlessness. A lumbar puncture at this time revealed the cerebrospinal fluid pressure to be 450 mm. of water. Chemical analysis of the fluid showed 38 mg. of sugar and 630 mg. of chloride per 100 cc. The cell count revealed 21 lymphocytes and 8 polymorphonuclear leukocytes per cubic millimeter of cerebrospinal fluid. A smear of the fluid showed yeast-like bodies characteristic of *Torula histolytica* and a culture produced a growth of *Torula histolytica*. Due to the patient's confusion and difficulty in swallowing, a polyethylene Levine tube was passed into the stomach for feeding. Sulfadiazine was given by this tube and later was given intravenously. Sodium Iodide was also given intravenously. On August 2 a lumbar puncture revealed the cerebrospinal fluid pressure to be 500 mm. of water. Chemical analysis of the fluid showed 8 mg. of sugar and 658 mg. of chloride per 100 cc. The cell count revealed 3 lymphocytes. A smear of the fluid again showed the *Torula histolytica*. On August 3 the patient began to run a fever, 100.2 F. per rectum, for the first time since admission. Her course from that time on was progressively downhill. She began having Cheynes-Stokes respiration on August 5 but this seemed to clear up with aminophyllin and positive pressure oxygen. On the follow-

ing day she seemed considerably more alert and could swallow small amounts of fluids for the first time in several days. However, this improvement was very brief. She died on August 7, eighteen days after admission to the hospital.

Necropsy

NECROPSY, A-51-88: The heart was enlarged, weighing 300 gm. The lungs weighed 1180 gm. together. The right lower and middle lobes were atelectatic. Microscopic examination of the lung tissue showed evidence of early consolidation. The alveolar spaces were filled with fluid and were infiltrated by large numbers of neutrophils. The brain weighed 1350 gm. The dura was thickened and grayish in appearance. There was a moderate amount of slightly cloudy spinal fluid present. The convolitional markings were slightly flattened and there were a few tenacious adhesions over both parietal areas and along the base of the brain. The brain substance was more firm than normal. The ventricular system appeared normal in size and configuration. Microscopic examination of sections from the brain revealed an extensive granulomatous inflammation of the leptomeninges. The inflammatory process consisted of a poorly organized mixture of epithelioid cells, a large multinucleated foreign body giant cells, plasma cells, lymphocytes and an occasional polymorphonuclear leukocyte. A large number of yeast-like fungi were present within the multinucleated giant cells and also extracellularly. These typically consisted of a central body, occasionally staining slightly with hematoxylin but in most instances relatively unstained and a clear space surrounded by a capsule. Occasional small buds were noted on these organisms.

Clinical Picture

The clinical picture of *torula* infection of the central nervous system is one of a meningo-encephalitis of slow onset. Intermittent headache of increasing frequency and intensity is the most frequent initial symptom. This may be followed by stiffness of the neck, symptoms of a focal brain lesion, irritability and, ultimately, profound mental disorders. Nuchal rigidity, positive Kernig's sign, ophthalmoplegia and papilledema are the manifestations most constantly observed on physical examination. The course is usually progressively downhill, with a fever seldom above 101 F., to death in coma with

respiratory failure²², as in the second case reported here.

Not infrequently, because of the nature of the pathologic alterations in this disease, causing an interruption in the flow and in reabsorption of the cerebrospinal fluid and provoking signs of increased intracranial tension, the presence of an expanding cerebral lesion is strongly suspected. Because of that, intracranial exploration is often carried out. No neoplasm, of course, is found and only rarely are there encountered torular granulomas, single or multiple, which are mistaken for neoplastic lesions.

Analysis of Cases

In an analysis of 178 cases of torulosis with central nervous system involvement, Carton and Mount found 42 cases in which an expanding intracranial or intraspinal lesion was suspected and an operation performed. In the 42 cases only 9 tumors, or granulomata, were found at operation and 2 at autopsy¹.

It follows that a correct diagnosis can be reached only on the recovery and full recognition of the causative agent. It is thought desirable, therefore, to present at this point a summary of the biologic characteristics of the organism causing torulosis.

Description of Causative Organism

The organism is a yeast, named correctly according to the accepted rules of nomenclature, *Cryptococcus neoformans*²¹. The name *Torula histolytica*, erroneously given to this organism in 1916 by Stoddard and Cutler¹⁹ as a result of their otherwise excellent study, is so commonly used that it cannot be abandoned without causing confusion. The term, *histolytica*, could well be dropped since it implies properties the organism does not possess.

The organism has a varied appearance, depending on whether it is examined in culture, in body fluids, or in pathologic lesions. Generally, it is a round to oval body surrounded by a transparent capsule some 3 to 5 times the size of the cell itself. It usually has a sharply defined double wall. Recently it has been demonstrated that the capsules of cryptococci contain serologically reactive substances, so that specific antisera reacting with the organisms produce a capsular swelling, akin to the Quellung reaction, seen between pneumococci and specific antisera. These antigenic properties, however, have

been of little use in the diagnosis and treatment in human cases¹. Budding forms are common. The organisms stain with the common dyes without uniformity. With hematoxylin and eosin, they take on a color which varies from bright blue to pink; occasionally they display no color at all. Generally, the cell body is Gram-positive while the capsule is Gram-negative; this also is not constant. A fairly dependable reaction is obtained with Wright's or Giemsa stain differentiating the organism clearly from leukocytes. The organism usually grows readily on routine laboratory media, but a faster and more luxuriant growth is obtained on blood agar, Sabouraud's agar or Loeffler's medium. It is quite resistant to drying.

The clinical diagnosis of torula meningoencephalitis is admittedly difficult, if not to say impossible, without the identification of the causative organism. It is a challenge that must be met in every instance of a chronic meningitis process in which tuberculosis and syphilis are excluded; in instances of increased intracranial pressure, with or without localizing signs, associated with pleocytosis and xanthochromia in the cerebrospinal fluid; and in any obscure disease of the central nervous system in which there is found a pleocytosis of the cerebrospinal fluid. In such situations the identification of the causative organism becomes imperative. The following laboratory investigations in this direction are found most useful:

Useful Laboratory Findings

1. The cerebrospinal fluid, unstained or treated with 0.2 per cent methyl violet in 1 per cent acetic acid, is best examined in a blood counting chamber or in a hanging-drop slide. With reduced illumination, the organisms may be readily identified as round bodies about the size of white blood cells, surrounded by a clear "halo" about 3 times as large as the cell. Buds are occasionally seen, and the interior of the cell may contain several globular bodies.

2. The cerebrospinal fluid, evaporated almost to dryness and emulsified with a drop of India ink on a slide, is pressed down hard with a cover glass to form a thin film. The unstained parasites, if present, contrast sharply with the surrounding dark field appearing as round bodies with a double wall and an enveloping wide, clear halo²³. This method may also be used in identifying the organism in culture.

3. A smear prepared from the sediment of centrifuged cerebrospinal fluid, stained with Wright's or Giemsa stain, will reveal the yeasts, if present, and because they stain homogeneously will be readily distinguished from white blood cells.

4. Culture. A quantity of cerebrospinal fluid is best planted on Sabouraud's blood agar, and Loeffler's medium. Within 4 or 5 days—occasionally within 24 hours²—round, raised, sharply defined, gray, non-hemolytic colonies will be seen. Unstained saline suspensions of these colonies will show the characteristic organisms, but the capsules are not so prominent as in "natural" material; they will be readily discerned, however, in India ink preparations. Other yeasts may be confused with *Torula* in cultures, however, a yeast with a wide capsule around it is nothing else but *Torula*.

5. Animal inoculation can also be done. Mice are injected intraperitoneally with fresh material or cultured growth. The disease proves fatal in 3 or more weeks and autopsy will disclose the characteristic lesions in most of the organs, including the central nervous system.

6. Other diagnostic methods such as serological reactions, skin tests and blood or urine cultures are generally unreliable.

Cerebrospinal Fluid Findings

The cerebrospinal fluid generally reveals fairly constant findings which deserve comment. The fluid is often xanthochromic and may be turbid. The pressure is almost always increased, sometimes to very high levels. A cell count (generally 200-800 per cu. mm.) usually reveals a high proportion of lymphocytes, although there may be up to 50 per cent polymorphonuclear leukocytes. It has been suggested that many of the presumed mononuclear cells are actually torulas; unless the possibility of torula infection is kept in mind and suitable precautions taken the organisms can easily be mistaken for lymphocytes. Sugar in the cerebrospinal fluid is usually lower than normal and may be sharply reduced or altogether absent. Chloride determinations often show a decreased content, sometimes going lower than in tuberculosis meningitis²⁷. The protein is almost always elevated.

Characteristic Lesions

Torulosis exhibits fairly characteristic lesions in the central nervous system. In exceptional instances there are granu-

lomatous lesions which are indistinguishable from tubercles. Usually there is a diffuse meningitis, from which the exudate typically extends into the perivascular spaces. The latter become distended, giving the appearance of multiple, grayish, gelatinous cysts in the brain substance. The exudate elsewhere is also gray and gelatinous. The mucoid consistency of the lesions is probably a coalescence of the capsular material of the organism². As a rule, there is little or no reaction in the brain tissue surrounding the distended perivascular spaces—which may sometimes reach great size—and the appearance of sharply demarcated, cystic areas filled with jelly-like material is typical of this disease.

Simulates Tuberculous Meningitis

Torulosis of the central nervous system simulates tuberculous meningo-encephalitis so closely that without the isolation of the causative organism the differential diagnosis is most difficult. Not only are the neurological features similar, but the association of pulmonary and central nervous system torulosis (about 1 in 5) provides another similarity and, hence, another obstacle. The x-ray appearance of pulmonary torulosis was reviewed by Greening and Menville⁵ who found that in early lesions the chest plate is fairly characteristic. *Torula* tends to involve the bases of the lungs and the densities are more sharply demarcated than those produced by tubercles. Older lesions usually become confluent, however, and there may be cavitation, miliary spread, or healing by fibrosis. Torulas have been found in sputum but patients with respiratory involvement rarely have a productive cough.

Mode of Infection

The mode of infection continues to remain obscure. Infections have been reported from all sections of the world and occur in all classes of society. The portal of entry is most probably the lung, as this organ is the second most frequently infected tissue. Thence the infection is probably carried to the other organs by way of the blood and the lymph channels²².

Treatment

Patients with torulosis of the central nervous system have been treated with a variety of therapeutic agents. In no instance was there established permanent

cure. Even the few who had an extended survival period were not well; in the preponderant number of instances a fatal outcome occurred within 6 months of the onset of symptoms.

No consistent results, either in vivo or in vitro, have been obtained with sulfonamides^{5,6,23}, iodides^{3,5,18,23}, arsenical³, quinine¹⁸, streptomycin^{16,24}, autogenous vaccine⁴, intravenous alcohol¹², actidione¹, or acriflavin¹⁴. Some investigators^{7,8} have found torula to be susceptible to penicillin in vitro. Hamilton and Thompson⁶ succeeded in reducing the cerebrospinal fluid parasite count from 1200 to 7 per cc. by the use of intrathecal penicillin; their patient subsequently died, but permission for autopsy was not obtained. Most investigators, however, have found penicillin to be ineffective, both in vivo and in vitro^{2,5,10}. Stone and Sturdivant²⁰ found x-rays effective in inhibiting the growth of torula in culture, but the effect of radiation in their patient and the patient of Warvi and Rawson²⁶ was questionable. The investigative work of Kuhn⁹ would suggest that hyperthermia might be used as a method of treatment in view of the fact that torula infection rarely produces high fever. His theory, however, loses some of its appeal in view of the observations of Cox and Tolhurst² that the few patients reported with high fevers died more rapidly than the average case. Hyperthermia has not yet been used in human torulosis, and in view of the uniformly hopeless prognosis, it seems worth trying, despite this theoretical objection. Streptothricin has been found to inhibit the growth of torula in concentrations which can be obtained in body fluids, including the cerebrospinal fluid; its absorption, excretion and distribution are roughly similar to that of streptomycin¹⁷. The toxicity of streptothricin has not been fully studied, but what evidence is available unfortunately points against its clinical usefulness, particularly in the central nervous system²⁵. It has not yet been used against disease, as far as we know, either in animals or humans. Since the cryptococcus is known to produce acid, alkalization therapy has been used recently, but the results have been inconsistent¹³.

Summary

1. Two cases of torular meningo-encephalitis are reported.

2. The difficulties in diagnosis are emphasized and effective diagnostic steps are listed.

3. The biologic characteristics of torula and the pathologic alterations it produces in the nervous system are reviewed.

4. Some of the therapeutic measures are discussed.

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Special Articles

Interval Report of Committee On Emergency Medical Service

G. Y. GRAVES, M. D., Chairman

Bowling Green

The general public and the doctors are both acutely unaware of the dangers of atomic attack, or else they feel that little can be done if we are attacked. Most of us feel that we are in communities so small that there is little danger to us. Those who live in small communities, however, are not safe from the chance bomb, ordinary bombing, or bacteriological and chemical warfare. All of these attitudes, therefore, are clearly fallacious.

We know that Russia is stockpiling atomic bombs and that she will use them. We have two prime targets in the state for bombing—Louisville and Paducah. Close to our borders are Cincinnati, Huntington, Oak Ridge, Evansville, and Nashville. In case of an emergency, we must prepare to help them.

Our task is to prepare for a disaster which might be as great as that of Hiroshima: 120,000 casualties one day, 40,000 deaths the first day, 20,000 deaths after the first day. Eighty-five per cent of these would suffer burn or mechanical injuries, 15% radiation injuries. It would require 40,000 to 50,000 units of blood the first week and probably 250,000 units of blood in all. With proper preparation, adequate warning and sufficient supplies, the number of deaths and casualties could be cut in half. This is the magnitude of our task.

The communities not likely to be bombed will have to supply the overwhelming majority of doctors to take care of the victims. For instance, if a bomb should land on Fourth and Broadway in Louisville, from 50 to 75 per cent of the doctors and hospital facilities would be destroyed.

We must have a plan to use all local physicians, to move physicians into the disaster area from the neighboring areas—in fact, the whole state must be used for support. We cannot wait until the disaster occurs and then organize—that would be much too late.

The committee has been working hard on these problems trying to evolve a satisfactory plan. We have met with General Lindsay, the Director of Civil Defense; with P. M. Crawford, M. D., Louisville, Deputy Director of Civil Defense Health Service in Kentucky; Clark Bailey, M. D., Harlan, President of the Association; and numerous regional and federal defense officials. We are slowly making a beginning.

The following statements constitute a report on what we have done. General Lindsay asked us to form four mobile support units at Louisville, Paducah, Ashland, and Bowling Green. We thought that the wealth of good medical manpower and skill at Lexington should not be overlooked, and asked General Lindsay to let us form a unit there. Already the medical heads of these units have been appointed, and recruitment of their personnel has been started. In addition, we have contacted the various other services that will go to make up the units, and these people are being enlisted.

We have urgently requested the state to stockpile sufficient supplies. Since we do not have enough money for all our requirements, we have studied the problem of getting the most vitally needed supplies. We have been assured that they will be furnished. There is no need of organizing the doctors without giving them the tools to do their job.

These mobile units are a good start, but will not be enough to take care of the task. In some capacity, every doctor in Kentucky will have to be used. He may take care of the sick at home or in the disaster area, or he may look after the evacuees. It is necessary to make a survey of all the physicians of the state, their training, type of work, hospital connections, state of health and army status. A questionnaire has been sent out to each physician in Kentucky to gather this information. We urge your cooperation in

returning this questionnaire, if you have not already done so. The county societies will be asked to aid us in assigning these men to the positions where they can best serve.

An effort will be made to acquaint every physician with the problem of atomic warfare. All second and third class cities will be asked to give courses on the treatment of atomic illness. Every physician is urged to attend. The neighboring county societies will be asked to attend these lectures. In addition, there will be a symposium of this subject during the scientific session on Wednesday morning, October 8, at the Annual meeting of the Association.

A survey of all the hospital beds and auxiliary hospital beds is being made.

The various hospitals are asked to lay

in emergency supplies, and to train additional nurse aids, technicians and other workers.

The Red Cross has been asked to train more people in the mass typing, drawing and storing of blood. It has also been asked to place its center farther from the center of the town. We hope to have a registry of the various blood groups—especially of group “O”—established at some point away from the disaster area, so that we can get blood quickly.

We must get out some training manuals, have practice drills with our aids, nurses, stretcher bearers and others. We must train First Aid workers and educate the public in methods of self-protection.

We must overcome the apathy that exists both in the profession and in the general public. We need your help.

What Constitutes A School Health Program

D. A. DUKELOW, M. D.

Chicago

There is a tendency to look upon the school health program as a collection of more or less unrelated parts rather than as an integrated whole. We speak of the *doctor's* examinations, the *teacher's* observations, the *nurse's* inspections. We talk of the *school administrator's* supervision, the *health officer's* cooperation, the *medical society's* participation. We say these phrases so often that even the people we are discussing occasionally develop possessive attitudes toward the phase of the school health program for which each is responsible. In the performance of school health functions, this possessive attitude sometimes produces a group of prima donnas striving for individual recognition rather than a smoothly operating team striving for child health.

To give us a goal to work towards we should define our concept of an ideal school health program. We must consider the means that are present or reasonably available for accomplishing our hopes. Our goals must be in terms of the needs of the people. They should motivate people to move forward on their own initiative. We must be sure that we know what we are trying to do with our school health program and why we are trying to do it. We must recognize that the objective to-

ward which we are working is the child and not the program; the guidance of growth into constructive channels, rather than the building of a program for the program's sake. Our objective is the production of children who have the kind of health envisioned by the definition of health “as complete physical, emotional and social well-being, and not the mere absence of disease.” This goal must be considered realistically in terms of the facilities and personnel that are present or reasonably available, and in terms of the needs of people and their willingness to use their own initiative to move forward. It is practical to keep our program within the experience and understanding of the people who must support it. There is an old adage on community organization that says “start where the people are and travel no faster than they can follow.” With these factors in mind, what could constitute a school health program?

The primary facility in a school health program is the school. A school, by definition, contains a faculty. This faculty may be a single teacher in a one room school, who has probably been trained in a Kentucky teacher training institution. She has a deep understanding of the rural child and his family, because she probably grew up in a rural home herself. With a little assistance she can become a very

powerful influence on the level of healthful living practiced in her school district. In larger centers the faculty will consist of several teachers, many of them better trained or more specialized than the teacher in a one room school and under the supervision of a school administrator. These school people have a basic health training. They attend workshops and conventions, and otherwise maintain their skill in observing the children in their classes. The superior teacher is the teacher who actually sees and recognizes any changes in physical appearance and behavior among her children and discusses them with the nurse or doctor. Our primary facility, then, is a school with all of the informed professional staff that the word "school" implies.

The county in which this school is located probably has a local health department. A health department implies a public health nursing service which serves the school or gives nursing supervision to the school nurses. The health officer and his engineer are available for consultation. Any school administrator can get this help just by asking for it. In fact, the better school health programs are based on a co-operative arrangement where the coordination of the two departments is close. Both are planning continuously with each other and with other community interests in the development and operation of the school health program.

In most instances the person who is the link between the health professions and the educators is the nurse serving the school. Her most valuable services are her aid to the faculty in observing and understanding the health problems of children, and her home contacts where she teaches parents the need for prevention and continuous medical supervision. We hear a great deal about the "nurse-teacher conference." Whenever a nurse and a teacher call each other by their first names, and discuss the problems of individual children without the formalities of protocol, I know that school has a school health program with a heart and that the youngsters are getting a worthwhile health program.

In or near practically every community served by a school will be found at least one physician and dentist in private practice. It can be fairly said that every community that will support a physician has one, and he is available to the school population because these children are in the

families that he considers his practice. Where there is ample medical manpower, the physician can afford to spend considerable time with the school health program. Where doctors are few and far between, the physician may be able to do no more than diagnose and treat the illnesses and defects which are referred to him by alert teachers and the nurse serving the school. In the absence of adequate medical care, an effort should be made to have trained nurses and teachers who can make selective referrals so as to conserve the physician's time and still care for the more serious health needs of the children.

The physician and the dentist belong to their respective professional associations and through these associations can give considerable support to the school health program. A medical society is the ideal unit to represent the physician in the broad planning that is necessary when evolving school health programs with school departments and health departments.

These four resources, the school, the health department, the medical society and its physician members, and the dental society and its dentist members, are the nucleus about which a school health program can be developed which is directed toward child improvement. These various resources must be fitted together with the other agencies and professions serving children into a smoothly operating unit in order to be most effective.

Now that we have visualized a team of people as the basic constituent of the school health program, we can consider some aspects of the classic subdivisions of the school health program. Health education is one of these, but it is more than a classroom exercise. Children are learning health attitudes constantly both in and out of school. Habit patterns are being established which will be carried throughout life. For example, it is one thing for a teacher to suggest the desirability of hand-washing before eating. It is something else again for the school which provides a school lunch or a place for eating a bag lunch, to fail to provide the soap, water and towels that are necessary for hand-washing, or if they are provided, to fail to arrange the school program so that there is time to use them. Learning must be supported by opportunities for practice of what is learned. It is quite important that the behavior patterns as-

sociated with eating are carried over into the non-school experiences of the child so that he will voluntarily wash his hands before eating even when he is away from the influence of the teacher.

The relationship between home and the school enters into this picture. A teacher may teach, but what she teaches to children must also be taught those children by parents. The parents must have help from such community resources as the health department and voluntary health agencies so that what they learn and pass on does not contradict but supports and complements what the children are learning through the school.

There has been a great deal of argument over the relative merits and the fundamental responsibilities of school health education and community health education. Each is necessary. They must work together to be effective because each is aiming toward a common end. If their teaching is in conflict, the children will be forced to choose between what is taught in their school and in their home. Whichever choice they make, there will be a weakening of the community relationships so necessary to sound growth and development.

Let us look momentarily at another area which, though it is closely associated with health education, is usually called health service. What are we trying to do here? Many people will say that we are trying to put our children into the best possible physical condition. But I think the greatest importance is to teach them how to use effectively the community resources that are available to them for the protection and maintenance of their own health rather than to teach them to expect someone else to always step in and provide health service for them.

The health service program of the school is a means of teaching children and their families about the kinds of services that are necessary for health maintenance and the use of community resources and facilities that provide these services. For example, a child meets the family physician in his office as a friend who will discuss with him, and help him solve, his health problems. The teacher and the school nurse will counsel the child on health matters but they do it in a manner of teaching rather than "patching." They are pointing out to the child the habits and customs that will help him improve

his health, the hazards of some behavior patterns, the kinds of services that are necessary for health improvement, how to obtain those services, and where they can be found. Health services as such become illustrations and laboratory exercises in a broad educational experience. Occasionally, we will find the idea of direct services so dominating in school health programs, that when the child leaves school at the end of his high school or college experience, he is completely ignorant of where to turn for help in case he should become ill. The school has handed him his health protection and medical service throughout his whole school life, but failed to teach him how to live in the world beyond the school, and select and use the existing facilities for health care.

In this country, with our constant striving for "bigger and better," practically all children hope to have more of everything than their fathers and mothers had. This is as it should be. With this striving for improvement, children can best be taught living habits and develop aesthetic ideals under conditions that are better than those they knew at home. You all can cite instances where children have been subjected to proper lighting at school, and then have persuaded their parents to improve lighting at home. Habits of cleanliness and a desire for attractive surroundings learned at school go home with the child. It is for this reason that healthful school living becomes an important factor in the school health program. But far more important than a child's momentary health, are the habits that he is learning and the attitudes he is developing toward attractive surroundings, toward means of health protection, and towards those little factors that make gracious living almost automatic.

You have asked me to give you my idea about what constitutes a school health program. Briefly, I would summarize my remarks by saying that a school health program consists of the personnel and material necessary for the development of the attitudes and habit patterns in our children that will cause them to want to be healthy, and will give them an understanding of how to protect their health and use the resources that are available for correcting health defects whenever they may develop. This school health program has as its primary objective the

physical, emotional and social improvement of the children who will head the families of tomorrow, so that not only will they be stronger as individuals, but will understand the problems of community health and will be both willing and able to work with each other for the further improvement of the community in which they live. To perform this kind

of a program, there must be an understanding and cooperation between education, public health, and the health service professions in the complete planning and execution of a community-wide program which may begin in the school, but which has its ramification throughout the whole community in which children and their families live.

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KENTUCKY PHYSICIANS ARE DOING SOMETHING ABOUT IT

It has not been more than one or two decades ago when a considerable majority of the physicians in Kentucky looked askance at organized medicine. It was fashionable in those days to say that most doctors interested in organization work were "medical politicians" seeking personal glory from whatever associational honors they were able to achieve.

While those allegations were not true in the vast majority of cases, we are glad that fewer and fewer statements of this sort are being made. Today's leaders in organizational work are largely unsung heroes. The majority of the members of the Association are not aware of the size of the load of organizational work that is carried by many busy Kentucky practitioners. Their contribution is made at considerable personal sacrifice with no thought of personal gain. Why do they do it?

An analyst might ascribe a number of reasons. World War II very likely had some influence. The realization that physicians could not in this changing world, live in an atrophied professional orbit, however high their motives or however clear their consciences were. For their own good, more particularly for the good of their patients, they began to feel it was desirable to be well-rounded citizens. The development of a brand of politician and political "do-gooder," eager to promote their own fortunes at the expense of conscientious physicians who did not know how to fight back, may have caused increasing interest in organized medicine. There are perhaps other good reasons.

Activity is moving ahead on any number of fronts. Committees, agencies and officers are performing in a way never envisioned a couple of decades ago. For instance, who would have thought in those days that five men would travel a total of fourteen hundred miles without any compensation to spend an afternoon

trying to settle grievances that patients had against their colleagues? Yet it is being done now as a matter of course.

In pre-World War II days, would four men have felt that it was indicated for them to have traveled a total of 1160 miles—after some president had named them to a committee—to try to plan ways and means of promoting closer cooperation and better relations with another honorable profession in the healing arts group. And again in pre-war days, do you suppose approximately fifty physicians would have left lucrative practices to have attended a Rural Health Conference? Would they even have been interested in sponsoring such a meeting?

We could go on and on listing examples like those noted above which illustrate the dissipation of the old idea and point up the acceptance by the modern physician of his obligations. It is pertinent here to point out at this time that activity sponsored by the Association in the opinion of some close observers, has increased four or five fold in the past three years. No thinking physician will not agree that this is a most healthy sign.

It is also pertinent to direct attention to the fact that much of what is going on now is in the blue printing stage. Progress in many areas of activity will be slow, and discouraging. It is true of the activities of the Association as a whole, the impact upon the public, all the good that will grow out of what is being done now, will not be totally apparent for years to come.

Physicians in Kentucky have much to be thankful for. Medicine has been good to us. Yet it is equally true—and most encouraging—that our members realize that with the benefits derived from our profession go solemn and well-defined responsibilities and that our members have accepted these obligations and are doing something about it.

THE MEDICAL PROFESSION'S POSITION ON THE DEFEATED SOCIAL SECURITY BILL

Many observers feel that the defeat of the bill to amend the Social Security Act, (H. R. 7800) on May 19 will become a considerable political issue in the fall campaign. Because of this and since the Fair Deal Press has angrily charged that the American Medical Association in defeating the bill is standing in the way of social progress, it seems indicated to look into the background of this subject.

H. R. 7800 was introduced by Congressman Doughton on Monday, May 12, and referred to the House Committee on Ways and Means, printed copies of the bill not becoming available until Wednesday, the 14th. With an imposing number of other bills before it, the Ways and Means Committee considered the bill immediately and reported it favorably on Friday, May 16—without public hearing—with the request that action be taken on Monday, May 19 under suspension of the rules.

The measure came to the floor of the House, one week after it had been introduced, under the suspension rule, which limited debate to 40 minutes, forbid amendments, and provided only for vote on passage of the bill. The necessary two-thirds majority vote, required for passage of the bill under this rule was not forthcoming—there being 149 votes for and 140 votes against passage.

The defeated bill would have provided a number of amendments to Title II of the Social Security Act, which deals with Old Age Survivors' Insurance benefits. Among the more noteworthy provisions was the clause to increase to a maximum 12.5 per cent old age and survivors' pensions. The A.M.A. did not object to any parts of the measure, including the above, except Section 3.

Under Section 3, dealing with the permanently and totally disabled, the Federal Security Administrator was empowered to: (1) determine what constitutes permanent and total disability; (2) establish the type of proof necessary to establish permanent and total disability; (3) provide by regulation when and where physical examinations should be taken; (4) be

authorized to pay travel expenses and subsistence incident to taking of such physical examinations; (5) be authorized to prescribe the name of the examining physician or agency (including federal installations); (6) establish the fees; and (7) provide power to curtail Old Age and Survivors' Insurance benefits because of non-compliance with regulations of this section.

This was the section of the bill the A.M.A. resisted—it did not object to the remainder of the bill. While the measure did not establish permanent and total disability benefits, it would have set up a precedent and framework for the adoption of such benefits in the future. The enactment of H. R. 7800 would have vested in the Federal Security Administrator immediate control of a large segment of the population and the medical profession.

According to reports, many of the Congressmen who opposed the bill voted against it as much because of the way it was handled as they did the provisions of it. They felt that to introduce so important a bill, deny public hearings, report it out at the close of the week and attempt to force it through the following Monday constituted political maneuvering of an unpardonable nature. George F. Lull, M. D., A.M.A. Secretary and General Manager, in a newspaper story was quoted as saying the bill was defeated because of the "deception on the part of its sponsors."

At this writing, the bill is not dead, the Committee may delete Section 3, hold hearings and amend or return it to the House open to amendment. Immediately after the May 19 vote, Representative Reed introduced a substitute bill eliminating the objectionable features of Section 3 of H. R. 7800 and providing for the increasing of permitted monthly pension income to \$100. There seems to be no rush, as we go to press on the part of the Fair Dealers to increase pensions now, and nothing has been heard from the matter.

THE PROFESSIONAL TITLES ACT

Once upon a time, and not in the too far distant past, when someone yelled, "Is there a Doctor in the house?", there was little doubt as to who was meant. Nowadays it might be rich man, poor man, beggar-man, thief: doctor, lawyer, or merchant chief. The rich man might be a Doctor of Science; the poor man a Doctor of Divinity; the beggar-man—perhaps a Doctor of Philosophy who has failed to philosophize remuneratively; (after due consideration we have decided not to label the thief); the lawyer, of course, is a Doctor of Laws, and the doctor?—well, he might be a Doctor of Naturopathy, Swedish Massage, Physiotherapeutics, Phytotherapy, Chiropody, Chiropractic, or possibly he might be a Dentist or a Doctor of Medicine.

A similar dilemma confronts Mr. John Q. Public when he is in need of medical attention and sees a sign that reads "Dr. John Doe."

To alleviate the situation, and to assure the patient that he can select the type of practitioner that he prefers, with the sponsorship of Kentucky State Medical Association and the State Board of Health, the 1952 General Assembly enacted a piece of legislation known as "The Professional Titles Act." The Act is not complex and has but two aims. One is to

prohibit persons professing to be engaged in practicing one of the healing arts from using the title "Doctor," or in any way holding himself out as a doctor unless he has actually been graduated from, and has had conferred upon him a doctor degree from a school authorized to confer such a degree. The other is to require all persons so entitled who employ the title of Doctor upon signs or written material to identify the particular type of doctor degree that he holds, either by suitable words or initials.

As simple and innocuous as the legislation appears to be, it has posed some questions and problems for physicians. The headquarters office and the State Board of Health have received a number of inquiries in regard to compliance with it.

Neither the State Medical Association, however, nor the State Board of Health is authorized to interpret the act. Only the courts may do that. Nor is the State Board of Health or the Department of Health charged with its enforcement of officers. Neither can any person or agency authorize a doctor to ignore, or in any way fail to comply with the Act even though it may seem plausible, or economically advisable to the doctor to do so. It is good legislation and we predict that it will prove to be beneficial to the profession.

ORGANIZATION SECTION



EUGENE M. BRICKER, M. D.
St. Louis, Mo.



ARTHUR E. COLWELL, M. D.
Chicago, Ill.

Drs. Bricker and Colwell To Be Heard At Annual Meeting

Arthur R. Colwell, M. D., Chicago, and Eugene M. Bricker, M. D., of St. Louis are among the long list of nationally recognized guest speakers who will appear on the scientific program of the 1952 Annual Meeting of the Association, in Louisville, October 7, 8, and 9. Clark Bailey, M. D., Harlan, President, said in discussing the unusual strength of this year's program.

Dr. Colwell, an internist, graduated from Rush Medical College in 1921. He is Chairman of the Department of Medicine, Northwestern University; Chairman of the Division of Medicine, Passavant Memorial Hospital and President of the American Diabetes Association. In addition, Dr. Colwell is the author of numerous medical publications including two books on diabetes mellitus.

Dr. Colwell's paper, which will be given during the Thursday Morning scientific session October 9 (see program) is entitled "Rationale of Good Control in the Treatment of Diabetes Mellitus."

Dr. Bricker, a native of Illinois, graduated from the Medical School at Washington Uni-

versity in St. Louis, 1934. He spent five years in Barnes Hospital in St. Louis, where he received his surgical training, and for the next three years was Chief of Surgeons at the Ellis Fischel Cancer Hospital. He was senior consultant in plastic surgery in the European Theatre of Operations from 1943 through 1945. He has his American Board in both surgery and plastic surgery.

"Advances in the Surgical Management of Carcinoma of the Colon" is the subject Dr. Bricker will discuss. He will appear on the Wednesday Afternoon scientific session October 8.

Nominating Committee For 1952 Announced By Speaker

Hugh L. Houston, M. D., Murray, Speaker of the House of Delegates of Kentucky State Medical Association, after consultation with the President and President-Elect of the Association and the President of the Jefferson County Medical Society, has requested the following members of the Association to serve on the Nominating Committee for the 1952 Annual Meeting:

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OF PHILADELPHIA

Woodford B. Troutman, M. D., Louisville, Chairman

Howell Davis, M. D., Owensboro

Charles B. Stacy, M. D., Pineville

Dr. Houston emphasized that all members and county medical societies having suggestions for nominations for the various associational offices should present them to the committee members.

The Speaker pointed out that at its May 8 meeting, the Council asked that the Nominating Committee meet at a duly advertised place immediately after the first session of the House of Delegates, Monday evening, October 6, at the Columbia Auditorium, and hear all suggestions that might be offered. Also that the Council asked the Committee to report its list of nominees for the various offices at the Second Scientific session, Tuesday afternoon, October 7.

Officers for the 1952-53 year will be elected at the second session of the House, Wednesday evening, October 8. Dr. Houston stated that in addition to the nominations presented by the committee, nominations could be made from the floor.

Sustained Advances Cited By Dr. Cline, Retiring A.M.A. Head

"The past year has been one of sustained advance in scientific knowledge, in improvement of medical care and in making that care more easily available to our people," John W. Cline, M. D., San Francisco, said in his valedictory address before the American Medical Association over a nation-wide radio hook-up the evening of June 10 in Chicago.

Dr. Cline succeeded Elmer L. Henderson, M. D., Louisville, as president of the A.M.A. one year ago at Atlantic City. The outgoing president made his address at the occasion of the inaugural of his successor, Louis H. Bauer, M. D., Hempstead, New York.

Dr. Cline, who spoke at the Centennial President's Luncheon of our Association in 1951, stated that medical education, medical care and health generally among the American people has reached levels previously unattained in the world.

According to Dr. Cline, the number of physicians is increasing, distribution of them is improving and that positive progress continues in the field of voluntary health insurance. He said this progress would continue but urged all Americans to be alert and vigilant in the critical year of 1952.



Dr. Thompson, left, poses with Dr. Cave at the French Lick Session

Dr. Jackson Made Ky. Surgical President At French Lick

E. W. Jackson, M. D., Paducah, was elected president of the Kentucky Surgical Society at its annual meeting in French Lick, Indiana, on May 24, 1952, which was attended by 98 physicians, most of whom brought their wives.

W. Vinson Pierce, M. D., Covington, was chosen Vice-President and Francis M. Massie, M. D., Lexington, was re-elected Secretary and Treasurer. Malcolm Thompson, M. D., Louisville, is the retiring president. Guest speaker for the 1953 meeting will be Daniel C. Elkin, M. D., Emory University, Atlanta, Georgia.

Featured on the 1952 program as the guest speaker was a native of McCracken County, Henry W. Cave, M. D., of New York City, who discussed "Management of Massive Hemorrhage from Upper Gastrointestinal Tract."

Other speakers, all members of the Society, taking part in the scientific session were: J. Duffy Hancock, M. D., Louisville; A. E. Grimes, M. D., Lexington; Robert Lich, Jr., M. D., Louisville; Joseph E. Maurer, M. D., Louisville; and Laman A. Gray, M. D., Louisville.

Dr. Cave, at the business meeting of the Society, was elected as an Honorary Fellow of the Society. Place for the 1953 Annual Meeting was not determined. President Thompson was authorized to appoint a committee to act with the Committee of the Kentucky State Medical Association to help raise funds for the support of the McDowell Home in Danville. Dr. Massie said in commenting on the business session.

New members elected to the Society at the French Lick meeting this year are: Drs. E. S.

Allen, H. B. Asman, Wm. H. Bizot, W. Burford Davis, Walter I. Hume, all of Louisville; James E. Hix, Owensboro; Herman E. Martin, Ashland; W. L. Cooper, and T. R. Miller, of Lexington.

Physicians invited as guests to the meeting were: M. L. Barnes, W. P. Blackburn, Harold Berg, T. R. Bryant, Winston Bloch, C. W. Caldwell, Delmas M. Clardy, B. Earl Caywood, Sam S. Clark, Marion O. Crowder, H. C. Denham, Jesse T. Funk, John B. Floyd, R. F. Grise, and Hubert C. Jones.

Blaine Lewis, W. V. Lee, M. A. Lucas, E. K. Martin, C. G. McLean, V. E. Masters, Herman R. Moore, H. H. Moody, R. J. Noer, G. M. Peterson, Shirley Price, Dale Royalty, Richard Rust, Charles C. Rutledge, W. T. Swartz, M. B. Melborn, and Charles R. Yancey.

Dr. Horine Honored During Drake Ceremonies in Cincinnati

Emmet Field Horine, M. D., Brooks, Official Historian of the Kentucky State Medical Association and a nationally recognized authority on medical history, was one of the central figures in the Daniel Drake Day Ceremonies sponsored by the University of Cincinnati, the Cincinnati Academy of Medicine, Historical and Philosophical Society of Ohio and other groups on May 27.

The memorial exercises marked the centennial year of the death of Dr. Drake. In addition to Dr. Horine's address, entitled "Daniel Drake: Cincinnati Unique," other high points of the activities honoring Dr. Drake were: the adding of a commemorative plaque on his grave stone, at which M. A. Blankenhorn, M. D., University of Cincinnati, Professor of Internal Medicine spoke; the conferring of honorary degrees by the University on Drs. Horine and Blankenhorn; and a special 20-page supplement of the Cincinnati Enquirer on Sunday, May 25.

In presenting Dr. Horine to the University of Cincinnati President, Raymond Walters, who awarded Dr. Horine with the honorary Master of Arts Degree, the University's Professor of History of Medicine, David A. Tucker, Jr., M.D., said of the Kentucky Cardiologist "by many generations of students he is remembered as an inspiring and scholarly teacher and by a host of patients as a wise counselor and humane physician."

In addition, Dr. Tucker said, "For more than 25 years, Dr. Horine has made a diligent study of the life and time of Daniel Drake, founder

of the Medical College of Ohio, of which the Medical College of the University of Cincinnati is the lineal and legal successor."

Dr. Tucker continued, "Dr. Horine has edited from the original letters a new and complete edition of Drake's 'Pioneer Life in Kentucky' and has written a definitive 'Life of Drake,' now in manuscript but presently to be published in book form. He has also made significant contributions to our knowledge of Drake's work in the introductions to reprints of Drake's 'Letters on Slavery' and 'An Inaugural Discourse on Medical Education.'"

"It is peculiarly fitting, therefore, that the University of Cincinnati should confer an honorary degree on one who throughout a long period of medical service has upheld the dictum pronounced by Drake, namely: 'That medicine is studied as a physical science; it should be practiced as a social art.'"

The 1952 Annual Meeting of the Kentucky State Medical Association, October 7, 8, and 9, will memorialize Dr. Drake.

KSMA-Dental Committee Seeks Approval of Program

A well defined program, designed to strengthen and make more effective the relationship between the dental and medical professions, will be presented to the Executive Committee of the Council at its next meeting, Thomas J. Crume, M. D., Owensboro, Chairman of the K.S.M.A. Dental Committee has announced.

Dr. Crume said that his committee met in the Headquarters Office on May 15 and gave careful consideration to a number of points that will be included in his Committee's proposal. While he would not discuss any of the points in the proposal, specifically until they are officially approved and thus become the Association's policy in this field, he did indicate the program would be implemented at the grass roots.

The next step, according to the Chairman, would be to meet with the liaison committee of the Kentucky State Dental Association, and undertake the development of plans that were mutually agreeable.

The K.S.M.A. Dental Committee was first appointed in 1951. The May 15 meeting was the first for the 1951-52 group. Other members of the Committee are: Millard C. Loy, M. D., Columbia; Henry V. Johnson, M. D., Georgetown; Allen L. Cornish, M. D., Lexington; and R. Ward Bushart, M. D., Fulton.

Interns, Hospitals Complete First Year Under Matching Plan

The new Matching Plan for Internship Placement, which was participated in by interns from Kentucky and hospitals of this state, and designed to assist both the hospital and intern in getting together, has completed its first year of operation on a national basis.

The plan was developed in an effort to find an orderly manner of distributing approximately 5,800 students among 10,500 internships. The new effort is sponsored by the National Inter-association Committee on Internships.

According to the plan, each student can apply to any hospital, but he must list his choices in order of preference. Each participating hospital also submits a preferential list of the students who have applied to it. Hospitals and students are at liberty to investigate their reciprocal interests to the fullest extent, but not to demand commitments before the announcement of the results.

The student and hospital are then matched, the student receiving the internship rated highest on his list insofar as is possible, if this agrees with the hospital's evaluation of him.

John M. Stalnaker, Director of Studies for the Association of American Medical Colleges, in his report on the first year's results, quoted the dean of one medical school as saying, "Never before in my 17 years of experience have internship appointments been handled so smoothly."

Approximately 95 per cent of this year's interns participated in the plan, and some 98 per cent of the hospitals offering internships were participants, according to the Association of American Medical Colleges.

Fayette Dinner Attended By 233

Two hundred thirty-three people were in attendance at the annual dinner meeting of the Fayette County Medical Society, held May 15, 1952, at the Lexington Country Club.

Of this number, 115 were members of the Fayette Society. Leon Schiff, M. D., Associate Professor of Medicine of the University of Cincinnati, was the guest speaker. His subject was "Differential Diagnosis of Jaundice."

Out-of-town guests who attended the meeting came from as far away as Maysville, Hazard, London, Springfield and Louisville. Officers of the Fayette County Society are: Richard G. Elliott, M. D., President; Rankin C. Blount, M. D., Vice-President; and John B. Floyd, M. D., Secretary-Treasurer, all of Lexington.

Indiana, Memphis Groups Name New Staff Appointments

Robert J. Amick has been appointed Field Secretary for the Indiana State Medical Association and Robert C. Bird has been named Executive Secretary of the Memphis-Shelby County Medical Society (Tennessee) according to announcements made by our neighboring medical organizations.

Mr. Amick served as a full Lieutenant in World War II, and was employed by the Blue Cross before going to the ISMA. Well known in New Albany and Jeffersonville, he will spend the major part of his time promoting associational activities in Southern Indiana.

The Memphis Society, having only few less members than the Jefferson County Kentucky Medical Society, has installed Mr. Bird as its first lay executive. Mr. Bird spent three years in the Army during World War II and has had newspaper experience.

Rural Scholarship Fund Aiding 42 Medical Students

The Rural Kentucky Medical Scholarship Fund is at the present time aiding 42 students, of whom 10 are Seniors, 10 are Juniors, 10 are Sophomores, and 12 are Freshmen.

According to a recent report, given by Raymon F. Dixon, Secretary, at the Rural Health Conference, the Scholarship Fund, contributed by Kentuckians both within and without the profession, now totals \$154,023.00. Out of this amount, one hundred forty-one loans, totalling \$100,450.00, have been granted to 64 students since it has been in operation.

The Fund is administered by a Board of Trustees of which C. C. Howard, M. D., Glasgow, is the chairman. The Board is composed of 16 members who represent the Medical Association, the Medical School, the Farm Bureau, the P.T.A., and others who have interest in the program.

According to the plan of operation, the Board carefully interviews each applicant for the scholarship to determine his fitness for and interest in rural practice. The student aided must agree to practice in a rural area approved by the Board for at least as many years as he is aided by the Fund. He also agrees to repay the amount borrowed after he is established in practice. Only 2% interest is charged.

The Board prefers to make loans to students during their entire four years in medical school, Mr. Dixon said.

Dr. Jilson Heard By 200; Student AMA Makes 52-53 Plans

The University of Louisville chapter of the Student A.M.A. closed its first full school year of activity with a meeting late in the term featuring W. R. Jilson, M. D., Frankfort, Peter A. Overstreet, President of the chapter and now a senior in the Medical School, has announced.

More than two hundred students and guests of the chapter, including a number of Louisville physicians, heard the geologist give what was described as a "most engaging" account of the history of medicine in Kentucky from 1750 to 1850. Special attention was given to some of the leading physicians of the period.

The president of the local chapter of Student A.M.A. said plans have been drafted for increased activities of his organization for the new school year starting in September. Under the by-laws, at least four meetings of the chapter must be held, he said, and the programs are being tentatively arranged for each. In addition, advantages of membership in the student organization among the enrollment will be vigorously promoted.

The Student A.M.A. was organized early in 1951, and the local group is one of the charter chapters. Charles McGaff, Louisville, a senior in the medical school, was the first president. Mr. Overstreet praised the contributions Mr. McGaff had made in getting the chapter organized.

The American Medical Association offers all possible assistance to the Junior group and sponsors the Journal of the Student A.M.A. which is published monthly during the school year.

Complete First G.P. Residency

The first general practice residency has just been completed by Everett Davis, M. D., at the General Hospital, Louisville.

This is the first such residency ever offered by the General Hospital and the first in Kentucky. It has only been in the last few years that this has been done anywhere, and few know that there is available such a thing as a general practice residency, Dr. Davis believes.

Dr. Davis feels that the additional training he has received in the various subjects pertaining to general practice, has been very advantageous and worthwhile.

Seventh District Hears Dr. Bailey

The Carroll County Medical Society was host to the physicians of the Seventh District at the Madison Country Club, Madison, Indiana, Thursday, June 19, 1952, B. B. Baughman, M. D., Councilor, has announced.

Clark Bailey, M. D., President of K.S.M.A., was the guest speaker. The scientific program was given by physicians of the Seventh District: C. Wyatt Norvell, M. D., New Castle; Livingston A. Wahle, M. D., Shelbyville; and James T. Ramsey, M. D., Owenton.

New officers elected at the meeting are: C. Wyatt Norwell, M. D., New Castle, President; Smith H. Gibson, M. D., Williamstown, Vice-President; and B. F. Shields, M. D., Shelbyville, Secretary.

Officers of the Carroll County group are: H. C. Boylen, M. D., Carrollton, President and L. E. Oliver, M. D., Carrollton, Secretary-Treasurer.



At the Speaker's Table for the opening session of the Rural Health Conference May 7 and 8 for which 204 registered are: James Armstrong, formerly of Committee for Kentucky; Mrs. Albert Hatcher, former Chairman of Health Committee, Kentucky Farm Bureau Federation; Allen O. Grubbel, D. D. S., Secretary, Council on Dental Health, A. D. A.; Walter L. O'Nan, M. D., Chairman, K.S.M.A. Committee on Rural Health, presiding; Miss Myrtle Weldon, State Leader, Home Demonstration Agents, Extension Division, University of Kentucky; behind Miss Weldon, Aubrey Gates, Field Director, A.M.A. Council on Rural Health; Clark Bailey, M. D., President, K.S.M.A.; and Reverend Dr. Olin T. Binkley, Executive Committee on Rural Ministers Association, who gave the invocation.



At the morning session during the Rural Health Conference on May 8, Dean Frank Welch, College of Agriculture, University of Kentucky, shown above, was the first speaker. Clyde Sparks, M. D., Chairman, Council of K.S.M.A., presided. Other speakers included R. Haynes Barr, M. D., President-Elect of K.S.M.A.; D. G. Miller, Jr., M. D., Member, A.M.A. Council on Rural Health; Raymond F. Dixon, Secretary, Rural Medical Scholarship Fund; and Sewell Milliken, Chief, Division of Public Health Education, Ohio State Department of Health.

A.C.S. To Meet in New York

Many new surgical techniques and clinical developments will be presented at the 38th annual Clinical Congress of the American College of Surgeons to be held in New York City September 22 to 26.

Headquarters for the meeting will be at the Waldorf-Astoria. Alton Oshsner, M. D., New Orleans, 1952 President of the American College of Surgeons, will preside at the opening session at which Harold L. Foss, M. D., Danville, Pennsylvania, will be installed as President for the year 1953.

Dr. Bailey At First District Meet

Clark Bailey, M. D., Harlan, President of the Kentucky State Medical Association, was one of the featured speakers at the joint meeting of the First Councilor District and the McCracken County Medical Society in Paducah on May 28, J. Vernon Pace, M. D., Paducah, said.

Sharing the program given at the dinner meeting in the Ritz Hotel with Dr. Bailey was

Walter L. O'Nan, M. D., Henderson, Chairman of the K.S.M.A. Rural Health Committee and the State Rural Health Council. Dr. Bailey gave a brief picture of Associational activities and challenged his hearers to be "good stewards of what the doctors who have gone before us have left us." Dr. O'Nan described the purposes and benefits of the Rural Health Movement.

R.T.C. To Be Out-Patient Facility

C. E. Reddick, M. D., Director of the Division of Local Health Service of the State Department of Health, has advised all County Health Departments that the Rapid Treatment Center in Louisville will gradually terminate activities on an in-patient basis and become an out-patient facility.

It is planned to examine the patient at the R. T. C. and after diagnosis initiate the treatment. The patient will then be asked to return home and receive the remainder of the penicillin injections at the local Health Department. Under the current method of treatment, Dr. Reddick said, from one to four large doses of penicillin is adequate.



F. S. Crockett, M. D., Lafayette, Indiana, Chairman of the A.M.A. Council on Rural Health, is shown speaking during the Rural Health Conference at the dinner meeting at which Mrs. Charles Sewell, Administrative Director of the Associated Women of the American Farm Bureau Federation, was the featured speaker. Immediately to the right of Dr. Crockett is Mr. J. E. Stanford, Executive Secretary, Kentucky Farm Bureau Federation, who was Toastmaster; and Dr. O'Nan.

Thirteenth District Attracts 60

Approximately sixty physicians and their wives attended the first dinner meeting of the new Thirteenth District, held Tuesday, May 13, at the Henry Clay Hotel, Ashland, Clyde Sparks, M. D., Councilor, reported.

After the dinner, Clark Bailey, M. D., Harlan, President of K.S.M.A., spoke to the physicians and their wives. Following this, the wives left the room, during a brief interim, for entertainment provided by wives of the members of the Host Society.

The scientific program was presented by Marion Beard, M. D., Louisville, and Richard Elliott, M. D., Lexington, and was very well received.

Dr. Miller's Paper Gets Award

D. G. Miller, Jr., M. D., Morgantown, was the recipient of a \$1000 award that was made to the rural physician author of the medical paper adjudged the best to appear in "GP," the Journal of the American Academy of General Practice, for the year 1950.

The award was presented for the first time at the 1952 National meeting of the Academy in Atlantic City, for the paper entitled "Bites and Stings." With the award—which is presented only to a member of the Academy and which is decided on a point system set up by a committee from the Academy—goes a plaque. The award and plaque are contributed by the M & R Laboratories.

Dr. Scott To Head Second District

R. A. Scott, M. D., Dixon, was elected President and R. H. English, M. D., Henderson, Secretary of the Second Councilor District Medical Association at its Annual Dinner meeting attended by 54 physicians in Owensboro May 27, Walter L. O'Nan, M. D., Henderson, announced.

George T. Harrell, M. D., of the Boman-Gray Medical School presented what was described as a "most stimulating" discussion on "Myxedema." Wives of the members were also invited to the meeting, and were provided entertainment during the program by the wives of the Host Society members—the Daviess County Medical Society. Several out of state physicians were present at the meeting held at the Owensboro Country Club.

KSMA Lists New Members

The Association welcomes the following new members:

Bourbon—Ojars Podins, Paris.

Daviess—L. D. Moore, Owensboro.

Fulton—Walter Grenell, Fulton.

Fayette—O. B. McAtee, Lexington; Homer Martin, Lexington; Virgil Goodman, Lexington; Robert Kinnaird, Lexington; Cloyd McAllister, (Resident) Lexington; R. B. Simons, Lexington.

Pertinent Paragraphs

A bill permitting selective immigration of physicians has passed the House of Representatives and is now in the Senate. Under this bill, 50% or more of each country's quota of immigrants permitted to enter the U. S. annually could be reserved for persons with specialized training, including physicians.

One hundred seventy-six Naval Hospital Internships will be available in 1953, according to a recent announcement by the Navy. All applicants for these internships will be received and processed in accordance with the plan for internship appointments of the National Interassociation on Internships. Further information may be obtained by writing Surgeon General of the Navy, Bureau of Medicine and Surgery, Navy Department, Washington 25, D. C.

The Illinois State Medical Society voted to increase its annual membership fee to \$40.00 at the annual meeting in Chicago in May. The Ohio State Medical Association meeting the same month in Cleveland voted a \$5.00 a year boost in its annual dues.

Campbell County has made arrangements for the organization of a dental clinic for free treatment of underprivileged children. The plans call for expenditure of \$2,000 for the project. The Kiwanis Club took the lead in organizing the project along with members of Campbell County Fiscal Court, Campbell County Child Welfare Citizens' Committee, the Dental Association, city and county health officers and the State Health Department.

President's Page

"Diabetes is a disease which presents urgent problems not only to internists and general practitioners, upon whom the responsibility for the management of all but the most advanced and complicated cases of the illness usually devolves, but also to specialists in many other fields. It may be correctly defined as the disease of complications, since so many other ailments find the diabetic a particularly easy prey.

"The magnitude of the problem is increased twofold by the fact that, in addition to the approximate million known diabetics now under treatment, there is an estimated million in this country whose illness has not yet been discovered and consequently is not controlled. Pilot surveys indicate, too, that perhaps as many as two million more may be potential diabetics.

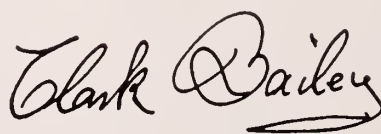
"It is essentially the physician's function and duty to discover the hidden diabetic, just as it is his task to supervise the treatment of those whose disease has been diagnosed. Consequently, it is of prime importance that any large-scale diabetes detection program be placed firmly in the hands of the medical profession, working through the organized medical societies."

The Committee on Diabetes of the Ken-

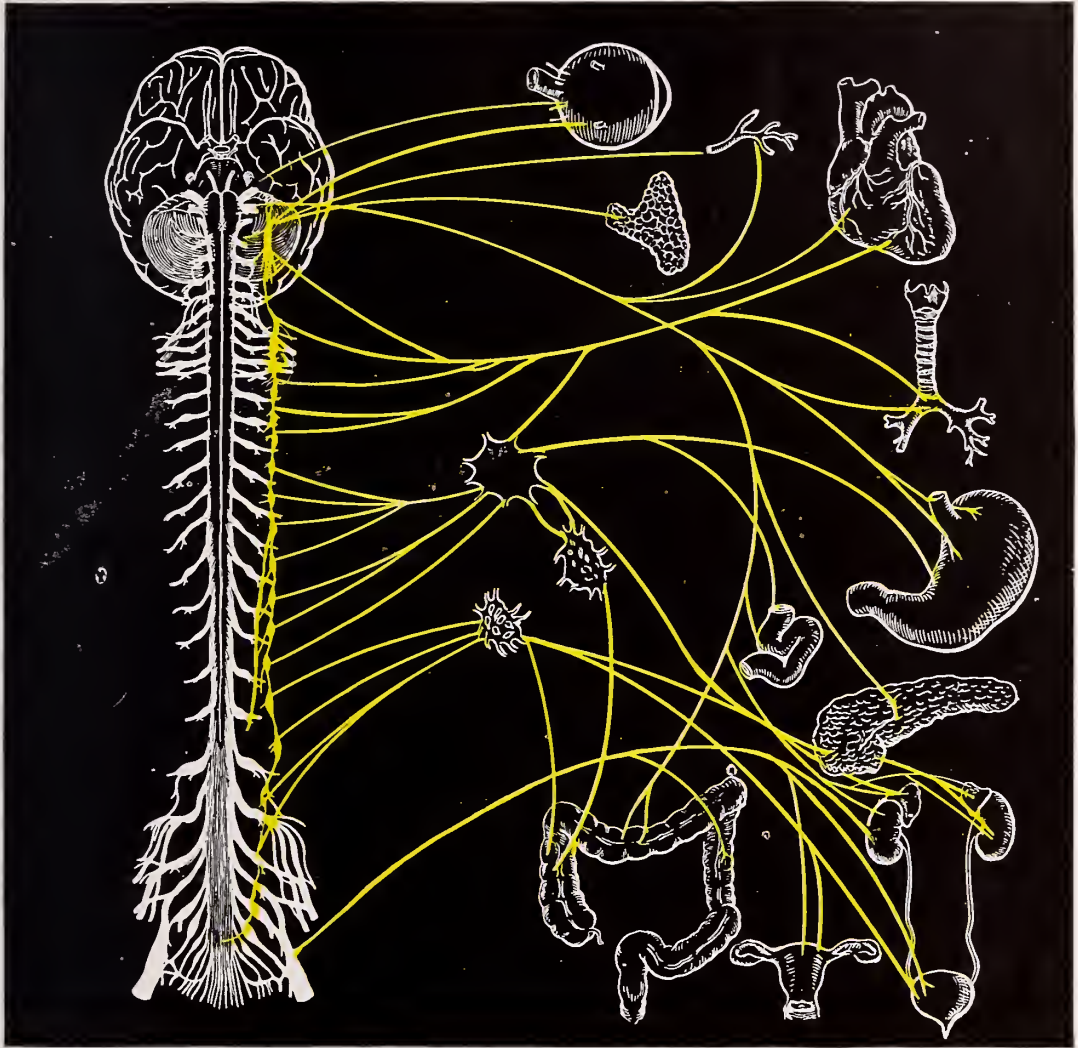
tucky State Medical Association is doing an outstanding work. The committee, under the leadership of its chairman, Carlisle Morse, of Louisville, has a most excellent record of activity. Just recently the committee met with members of the American Diabetes Association and discussed plans for a greater effort of participation in the Diabetic Detection Campaign. Your County Medical Society has been requested to appoint a committee for cooperation in the campaign this year.

It is interesting to note that the American Diabetes Association is the only voluntary health organization sponsored, controlled and operated by physicians. Since diabetes is one of the ten big killers of all diseases our responsibility of cooperating on a county level with the activities of this committee is indeed great.

The Diabetic Detection Campaign carried on last year under the direct leadership of your county medical societies accomplished much. Through cooperation this year with the program, our achievements should be greater. It is an opportunity for our profession through organization, functioning at the county level, to render a great service to the public in a more intensive effort to detect and control diabetes.



PRESIDENT



Excess neural stimulation over the parasympathetic subdivision plays an important role in such clinical conditions as peptic ulcer, certain forms of gastritis, pylorospasm, pancreatitis, spastic colon, bladder spasm and hyperhidrosis.

Banthine[®] Bromide (brand of methantheline bromide) is a true anticholinergic which inhibits parasympathetic stimuli, acting selectively on the gastrointestinal and genitourinary systems. It exerts little or no influence on the normal cardiovascular system. Banthine is supplied in oral and parenteral dosage forms.



County Society Reports

JEFFERSON

The April meeting of the Jefferson County Medical Society was held on April 21, 1952 at the Seelbach Hotel. Forty members were present for dinner and approximately eight additional members were present for the business and scientific session.

The meeting was called to order at 7:45 p.m., by the President, R. R. Slucher, M. D. The minutes of the previous meeting were read by Ralph Gettelfinger, M. D., and were approved as read.

The President called for reports of standing Committees.

Alice Wakefield, M. D., Chairman of the Committee on Physicians' Exchange, reported that the committee has met alone and with the professional Service Committee. The Committee will send questionnaires to each physician and Dr. Wakefield stressed the importance of replies so that plans for better future permanent service in the Physicians' Exchange may be made.

There were no other standing committee reports.

Dr. Gettelfinger read the following communications:

(1) Letter from the U. S. Department of Commerce stressing cooperation in the Louisville Scrap Mobilization Committee.

(2) Announcement from the University of Louisville School of Dentistry that they will sponsor a guest-lecture at a dinner meeting at the Brown Hotel on May 7, at 6:30 p. m. The speaker: Harold Hodge, M. D., Rochester, N.Y. His subject: "The Effects of Flourides on the Body." Members were cordially invited to attend.

(3) Letter from Walter L. O'Nan, M. D., Henderson, encouraging attendance of the May meeting of the Kentucky State Rural Health Committee. Minimum expected attendance is a representative from each county.

The following members were elected: Julian B. Hardaway, M. D., Active Membership; John M. Moorhatch, M. D., Associate Membership.

Scientific Program: 8:05 p. m. "Surgery of Stenotic Heart Valves," by Harold Harter, M.D., and J. Buford Davis, M. D. Slides were shown. There was discussion by Armond T. Gordon, M. D., with closing remarks by Doctor Davis.

Robert C. Long, M. D., Secretary

UNION

The regular monthly meeting of the Union County Medico-Dental Society was held at Our Lady of Mercy Hospital on Thursday, at 7:30 p. m. Preceding the meeting was a staff dinner at 6:00 p. m., and the regular hospital staff meeting.

The meeting was called to order by William Humphrey, M. D., President. The minutes of the last meeting were read and approved.

Drs. Cottingham, Humphrey and Graves were appointed as the Diabetic Committee for 1952.

The Society enjoyed the privilege of having Bruce Underwood, M. D., the State Health Commissioner, as the guest speaker. His subject was extremely interesting and very much up to date and instructive. He dealt with a number of very important matters, vital to our profession. It was a pleasure to have Dr. Underwood with us.

Members present were Drs. Allen, Carr, Conway, Humphrey, Graves, Higginson, Smith, Stewart, and Puryear. Dr. Atherton, from Clay was a welcome visitor.

A. W. Andreason, M. D., Secretary

WARREN-EDMONSON-BUTLER

The Warren-Edmonson-Butler County Medical Society met May 13, 1952, at the Helm Hotel, Bowling Green, for its regular dinner meeting.

The Society approved the formation of a Medical Auxiliary for the Warren County Society.

D. B. McIlvoy, M. D., Chairman of the Nursing Scholarship Committee, reported that our present scholarship holder is doing quite well and that he has five additional candidates for whom he hopes to find sponsors.

A Diabetic Committee, consisting of F. H. Moore, M. D., Chairman, J. T. Gilbert, Jr., M.D., and Rue O. Basham, M. D., was appointed. Sam Paris, M. D., gave a report on Blue Cross-Blue Shield Insurance.

The scientific program consisted of case reports—Hydatidiform Mole by James Freedman, M. D., and Generalized Cholesterolosis by Henry Harris, M. D.

Frank H. Moore, M. D., Secretary



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News Items

Julian B. Hardaway, M. D., a 1948 graduate of the University of Louisville School of Medicine, has located in Danville to do General Practice. Dr. Hardaway received his internship at Oliver General Hospital, Augusta, Georgia.

Guy Morford, M. D., has located in Owensboro for the practice of anesthesiology. Dr. Morford is a graduate of the Indiana University School of Medicine, class of 1944, and did his internship at Ball Memorial Hospital, Muncie, Indiana. Dr. Morford is from Kokomo, Indiana.

Arnold P. Combs, M. D., has returned to Kentucky to practice and has announced his association with the Lexington Clinic at Lexington. Dr. Combs graduated from the University of Michigan in 1937 and subsequently opened an office in Lexington, limiting his practice to Eye, Ear, Nose and Throat. Early in 1942 he became a medical officer in the Navy and after the war located in Minot, North Dakota.

J. M. Moore, M. D., and **Mrs. Moore**, of Princeton, observed their 50th wedding anniversary with an open house on Wednesday, May 14, 1952. Dr. and Mrs. Moore are both natives of Caldwell County. Dr. Moore graduated from the Hospital College of Medicine, Louisville, in the class of 1901 and has been engaged in general practice in Princeton since 1909.

John Hall Chrisman, M. D., Owenton, has celebrated his sixtieth anniversary as a practicing physician. Dr. Chrisman was graduated from the Kentucky School of Medicine in 1892 and first moved to Owenton in 1905.

Hollis Johnson, M. D., has become the Clinical Director of the Psychiatric Division, Norton Memorial Infirmary, Louisville. He has just completed two years in the Westchester Division of New York Hospital, White Plains, New York. A native of Paducah, Dr. Johnson graduated from the University of Louisville School of Medicine in 1945.

A. Lemuel Rosenblatt, M. D., has announced the opening of offices at the Wallace Building, 317 Wallace Avenue, St. Matthews, and will do Internal Medicine. Dr. Rosenblatt was graduated from the University of Louisville School of Medicine in 1948 and interned at the Louisville General Hospital.

James T. Ramsey, M. D., who has been practicing in Owenton, is now located in Frankfort where he will give special attention to the practice of Anesthesiology. Dr. Ramsey, a 1949 graduate of the University of Louisville School of Medicine, received his internship at the Good Samaritan Hospital, Cincinnati.

Conie Crittenden Lowry, M. D., formerly with the V. A. Hospital in Memphis, Tennessee, has announced his association with the Houston-McDevitt Clinic, Murray, for the practice of General Surgery. Dr. Lowry is a 1943 graduate of the Vanderbilt University Hospital and also received his internship there.

James B. Holloway, Jr., M. D., a 1945 graduate of the Yale University School of Medicine, has associated with the Lexington Clinic, Lexington, for the practice of surgery. Dr. Holloway interned at Duke University Hospital, Durham, North Carolina.

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Male Hypogonadism and Infertility

HENRY H. TURNER, M. D.

Oklahoma City, Oklahoma

It is estimated that 10% of marriages in the United States are infertile, and in about half of these it is the husband who is at fault. In fact, recent data of Hotchkiss¹ show that almost 10% of the adult male population fails to reach the usual standard for fertility, of 25 million spermatozoa per cc. of seminal fluid, and we have verified this in our survey of medical students. Therefore, while hypogonadism has signified, to most of us, the relatively uncommon state of eunuchoidism with its obvious anatomical and functional handicaps, it is clear that gonadal failure in the male is a frequent disorder of monumental social and economic importance.

Hypogonadism may be defined as a failure of the testis to carry on one or more of its physiologic activities. In addition to spermatozoa, the testis produces at least two hormones; it is actuated by two or perhaps three gonadotropic principles of the anterior pituitary; and certain of its hormonal functions are stimulated, to a degree, by adrenocortical hormones. Since a defect in this complex system may arise either in the testis itself or in the pituitary, and since the clinical features will vary with the time of life at which disease occurs, it is not surprising that eight different hypogonadal syndromes can be defined.² In fact, if we include the effects of mumps and radiation, and of cryptorchidism, there are thirteen or fourteen forms of hypogonadism.³

To reduce this massive problem to one of practical management, we may draw certain broad lines of division. We may distinguish between disorders *primary* to the testis and those *secondary* to pituitary insufficiency by means of urinary gonadotropic titer, usually determined as follicle-stimulating hormone, FSH. The determination is not ideal, as other gonadotropic factors are also involved, but in general a high titer, signifying greater than normal pituitary activity, accompanies primary or hypergonadotropic hypogonadism, and a low titer secondary or hypopituitary hypogonadism. Next, we may take into consideration the general principle that a patient deprived of testicular function *before puberty* often will be eunuchoid in appearance, measurements and function, whatever may be the etiology. Failure of the androgen-secreting interstitial tissue of the testis (Leydig cells) may bring this about primarily; failure of pituitary interstitial-cell-stimulating-hormone, ICSH, may do it secondarily; and it may also occur with failure in the seminiferous tubules, in a newly-described group of disorders the mechanism of which is still unsettled. In most eunuchoid patients, 17-ketosteroid excretion is low, reflecting diminished androgen production by the testes or possibly none at all—the urinary products being of adrenocortical origin. But because secondary sex characters do not regress greatly after loss of testicular function in the adult, the 17-ketosteroid determination reveals androgenic deficiency that cannot be recognized by physical examination, i. e., in non-eunuchoids.

Read before the Ephraim McDowell Memorial Meeting, the Centennial of the Kentucky State Medical Association, Louisville, October 2-5, 1951.

Finally, a systematic reliance on testicular biopsy^{1,4,5} reveals whether or not the semen contains everything that the testes are producing, and differentiates from the endocrine problems those men who have azoospermia with normal testes, i. e., the surgical problems of obstruction to the seminiferous duct system.^{6,7}

Because of the decisive importance of testicular histology in classifying the several forms of hypogonadism, the normal and abnormal features may be briefly reviewed. The testis is composed in the main of spermatogenic tubules and the androgen-secreting interstitial tissue. Androgen, or male sex hormone, is essential not only for the growth and development of the male genital tract, and evidently for the maintenance of spermatogenesis in the nearby tubules, but also for profound metabolic and psychic effects. In the immature testis the tubular cells are crowded and poorly differentiated, and the Leydig cells are few and small. The young adolescent testis, in this geographic region, shows the trend to differentiation and progression to the adult interstitial tissue. In the adult the tubule is placed within a thin basement membrane through which nourishment must pass to the intratubular cells. Within the tubule are the Sertoli cells which nourish the spermatocytes throughout their development and in which the young spermatozoa bury themselves before entering the lumen of the tubule. There is strong evidence for an endocrine function of the Sertoli cells, as well as the Leydig cells, and there is also considerable evidence for an estrogenic secretion by the testis although the cell-type responsible for it is still unknown.

The Leydig cells in the adult testis lie in discrete masses in the intertubular spaces, and show pale areas which progress with aging to vacuolization.

In analogy to the female, anterior pituitary FSH is responsible for stimulating production of the germinal cells; LH corresponds to ICSH and has a role in maintaining spermatogenesis. The possibility of still another gonadotropic hormone must be considered in relation to estrogen production. The analogous steroid hormones produced by the adrenal cortex, including androgen and estrogen, are presumably under the control of the same pituitary gonadotropic hormones.

Because they are the more obvious, as well as less common, we may first dispose of the eunuchoidal syndromes. Eunuchoidism is, of course, a purely descriptive term signifying that sexual maturation is incomplete because of androgenic deficiency before and at puberty. The genitalia are usually small (although in the non-classical eunuchoidism with tubular sclerosis they may not be); libido and potency are defective; the prostate is small; musculature may be slight, and the voice high-pitched; and the skeletal proportions show excessive length of the long bones—the pubis being more than half the patient's total height, and the span across the extended arms being greater than the height. In most forms of hypoLeydigism there is also a failure of spermatogenesis, and in the few eunuchoid subjects who have some spermatozoa, reproductive activity is further impaired by small prostate, seminal vesicles and varying degrees of impotency.

Primary eunuchoidism includes testicular aplasia and either actual or "functional" castration before puberty; the last-named applies to patients in whom no cause can be identified for the loss of androgenic activity. It also includes a proportion of the cases of tubular sclerosis, to be mentioned. The anterior pituitary being at least normally active, with no target testis to respond to gonadotropic stimulation, FSH is high, and by the same token nothing can be accomplished by treatment with gonadotropic hormones.

Secondary eunuchoidism may be the result of intracranial disease affecting the anterior pituitary, although it is unusual for such a process to single out the gonadotropic function and as a rule there is, rather, panhypopituitarism. When gonadotropic activity is lost in an isolated manner, there is usually no explanation; it is idiopathic. FSH is very low, or entirely absent, in either case.

In either primary or secondary eunuchoidism, urinary 17-ketosteroids are low. Androgenic function is suspended, regardless of the level of disturbance. But the hypogonadotropic or secondary hypogonadal syndromes should be distinguished for the practical reason that gonadotropic therapy is applicable: there is an interstitial tissue that may be capable of responding to chorionic gonadotropin.

Eunuchoidism with tubular sclerosis is a newly-described form of primary hypogonadism in which both the germinal epithelium and the Leydig cells are affected. The tubules are sclerosed, or hyalinized, and the interstitial tissue, while

it may seem abundant, fails to show normal maturation and does not have the usual appearance of secretory activity. If all patients with this disorder were eunuchoid, the matter would be quite simple, and one might conclude that the Leydig cells were inactive. But the identical histologic findings appear in quite as many patients who are *not* eunuchoid, and who excrete normal amounts of 17-ketosteroids, and, as a further complication, gynecomastia occurs in *some* of the patients in *either* group without any constant relation to eunuchoidism or (as appeared at first⁸) its absence. Several series of patients, embracing these clinical varieties, have been described under the terms sclerosing tubular degeneration,³ hyalinization of the seminiferous tubules,⁸ and, with gynecomastia present, the syndrome of Klinefelter, Reifenstein and Albright.⁹ The diagnosis rests upon the finding of tubular sclerosis at biopsy and the elevated FSH.

Spermatogenic deficiency in the non-eunuchoid may assume a wide range of forms, from entire absence of the germinal epithelium, or germinal aplasia,⁵ to simple oligospermia in which the biopsy fails to show any one striking defect. The testicular biopsy alone reveals the underlying condition, but the excretion of FSH varies in the several degrees of tubular failure or damage, and is valuable further information. FSH is found elevated in germinal aplasia, in tubular sclerosis, and in radiation-injury of the germinal epithelium—a disorder which may gain in frequency—all of which may conveniently be thought of as the severe tubular deficiencies. Albright's group³ found normal FSH in 8 patients with arrest of maturation at various stages of spermatogenesis, and in 15 men with generalized hypospermatogenesis with diminished production at all stages, as well as in men with simple oligospermia. To the extent that urinary FSH measures the patient's incapacity to respond to such gonadotropic hormones as we have available—and this is only a nominal extent—it follows that the severe tubular deficiencies are not indications for such treatment, while the disorders with normal FSH may be.

In practical terms, perhaps without regard for the niceties of classification, a patient who is partner to an infertile marriage may nor may not prove to be eunuchoid on examination: if so, that problem will have precedence for a time over the question of sperm-production. If not,

then a desirable diagnostic step is to x-ray the sella turcica to discover those rare but urgent cases of intracranial disease affecting the pituitary. If gynecomastia is discovered on examination, it is well to proceed at once to a testicular biopsy to determine whether the Klinefelter syndrome exists. If complete azoospermia is present, germinal aplasia may be considered, and the diagnosis made on biopsy, but the underlying disorder may equally prove to be tubular sclerosis, as biopsy will show. A history of severe exposure to radiation may tend automatically to place the patient in the class of extreme tubular damage; but one rarely has sufficiently precise data to gauge that exposure was of this severity, and indeed if the information were available preventive action would probably have been taken. The question can be answered with confidence, again, only by testicular biopsy. In all these instances, urinary FSH should be elevated. Bilateral obstruction of the ductal system is a frequent cause of complete azoospermia and should be suspected in those whose genital development and function are otherwise normal. The histological picture is that of a normal adult testis.

The greater number of infertile men do not have excessive pituitary activity, and show, on biopsy, a number of possible defects in spermatogenesis. In a general way these correspond to what is seen in the semen examination. An overall reduction in the *rate* of spermatogenesis, or at least an impression that this is present,⁵ is the usual finding with simple oligospermia. But arrest at specific stages may also be noted, and often abnormalities of the finished sperm are reflected in visible derangements of the spermatogenic process. As mentioned, the fact that FSH is low leaves room for a therapeutic trial with gonadotropic hormones.

Heretofore, at this juncture, the desirability of adequate rest and nutrition (including vitamins) and the deplorable roles of hard work, drinking and smoking would usually be mentioned by way of acknowledging that little effective treatment is available for functional azoospermia. Due reference would be made to the use of thyroid, since fortunately there are a small number of infertile men who benefit by it.

In 1950, however, Heller and his associates¹⁰ reported a surprising finding that markedly changes the expectation in sperm

deficiency. They had traced the progressive decline in sperm count following administration of large doses of testosterone. The subjects were institutionalized men to whom fertility was of no concern. Sperm counts were markedly reduced, as was often foretold, but when the semen and sections of the testes were examined a year or more later it was found that a striking rehabilitation of tubular structure and spermatogenic activity had taken place. Sclerosis and hyalinization, whether initially present or produced by hormone administration, had disappeared, and spermatozoa of good appearance were abundant. These investigators believed that such a method of treatment should be limited to men with elevated FSH and hyalinization of the tubules, other patients being eligible rather for gonadotropic therapy.

The first therapeutic demonstration of the method was recently reported by Heckel, Rosso and Kestel.¹¹ These investigators were not concerned, however, with the type of patient designated by Heller and others. Their demonstration dealt with 5 men having "a moderate oligospermia of undetermined etiology," which is doubtless the commonest diagnosis in infertility. As in the Heller cases, azoospermia was produced during treatment, and was followed in three to five months by a return to normal sperm counts, and by still increasing numbers of spermatozoa which greatly exceeded the initial levels. Our own experience has been similar. We await with interest the first report of conception presumptively achieved by one of these patients.

The precautions noted by the Heller group, as to selection of cases, may be applicable; information is not yet sufficient to warrant the wide use of male hormone in every variety of hypogonadism, and the phenomenon is one of rebound after suppression rather than actual gonadotropic stimulation which, for certain of the cases, would be theoretically ideal. If the available gonadotropins were more regularly effective, we should be much influenced by theoretical considerations of this kind. Instead it appears that, despite misgivings, simple androgenic therapy will be permitted to take the place of the accustomed methods of treatment and perhaps even of diagnosis.

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Surgery of the Acute Abdomen

HENRY W. CAVE, M. D.

and

WALTER WICHERN, M. D.

New York City

Introduction

Surgery in acute conditions of the abdomen is an intriguing and fascinating subject that constantly challenges the skill and the ingenuity of the surgeon with its many complex problems. The slightest and even a trivial injury to the abdomen may prove serious and even disastrous. Quick thinking and sound judgment are of the utmost importance, as the mortality rate in most instances, is in direct proportion to delay.

That one must be constantly alert and of open mind when confronted by the problem of the acute surgical abdomen is emphasized by the fact that the syndrome may be simulated by uncommon medical entities, such as acute porphyria, as well as by the more common surgical emergencies, such as acute appendicitis.

I should like to confine my remarks to a few of these diseases in the light of our recent experiences at The Roosevelt Hospital in New York.

Acute Appendicitis

Acute appendicitis is one of the most common of abdominal conditions to be considered. The conventional triad of pain, nausea and vomiting, and localization is well known, and the results of early operation have produced a gratifying improvement in the mortality rate. There remain, however, a significant number of patients who have acute appendicitis who have only anorexia, vague abdominal distress, minimal tenderness in the right lower quadrant and equivocal laboratory findings. These patients, too, warrant early surgical removal of the appendix and support the wisdom of early operation in those cases in which there is some question as to the diagnosis.

Acute Cholecystitis

At our hospital acute cholecystitis demands surgical intervention after a short period devoted to the restoration of fluid balance. When possible the gallbladder is removed. In the older age group, how-

ever, it remains necessary to do the more simple procedure of cholecystostomy in approximately 15%. It has been our experience that there is nothing to be gained by delaying surgery.

Acute Pancreatitis

The clinical picture of classical acute pancreatitis is one of the most dramatic of all surgical emergencies of the abdomen. Such a patient experiences sudden, excruciating, prostrating pain in the epigastrium that may radiate to the back or either flank. The pain is succeeded by severe reflex vomiting of the gastro-duodenal contents which seldom becomes fecal in character. The patient is in shock, of sub-normal temperature, dyspneic, slightly cyanotic, and perhaps jaundiced. In our experience, the purplish areas of discoloration that may appear in the flank or in the umbilicus do so only much later in the course of the disease, in 48 to 72 hours. Examination of the abdomen may reveal marked tenderness in the epigastrium with muscular spasm although in many of our cases there was almost a complete absence of muscular rigidity. The laboratory determination of the serum amylase is very helpful but may be of normal value 24 to 48 hours after the acute episode. At such times a determination of the urine amylase may be diagnostic for there is a definite lag in the urinary excretion of this enzyme. Emergency surgery is not carried out in the face of an obvious diagnosis of acute pancreatitis. Our treatment has been conservative, limited to constant gastric suction, atropine and ephedrine to inhibit the nervous stimulation of the pancreas, fluid replacement, and relief of pain. With regard to the relief of pain we have found para-vertebral blocks singularly successful.

Our experience with this disease has been disappointing, there have been nine deaths in forty-two cases, a mortality rate of 22%. Five of these nine patients who died in the past five years were operated upon; the diagnoses having been either perforated peptic ulcer or acute cholecystitis.

From The Roosevelt Hospital, New York City. Read before the Ephraim McDowell Memorial Meeting, the Centennial of the Kentucky State Medical Association, Louisville, October 2-5, 1951.

Intestinal Obstruction

Mechanical obstruction of the intestinal tract whether it be due to simple post-operative adhesions or to volvulus of the sigmoid colon presents two immediate problems: decompression of the proximal bowel and removal of the causative agent. The first problem is imperative and may be accomplished by means of the Miller-Abbott tube or upon the operating table. The second is of much less immediate importance and may be dealt with when the condition of the patient warrants it. The Miller-Abbott tube has been a very useful adjuvant, but it is pertinent to note that no delay should be tolerated in procrastination over whether or not the Miller-Abbott tube will be effective.

Perforated Peptic Ulcer

Approximately one of every three hundred admissions to the Roosevelt Hospital is for perforated peptic ulcer. The great majority of the patients are easily diagnosed, severe epigastric pain, prostrating pain, that usually occurs shortly after eating or drinking. Eighty-five per cent will give a history of previous ulcer symptoms if diligently questioned, and another seven per cent will have had previous surgery for peptic ulceration. The abdominal findings are nearly always those of generalized peritonitis with diffuse abdominal tenderness, muscular rigidity, and absent peristalsis. Liver dullness is absent in forty-five per cent and free air under the diaphragm is demonstrable in seventy per cent.

Two members of our staff, Dr. Henry Kingsbury and Dr. Earl Peacock, have recently reviewed the last 170 cases admitted to this hospital. They have found that eighty per cent of the patients in this series were operated upon an average of 6 hours following the first symptom of perforation. Subsequent to hospital admission approximately 2 hours was used prior to operation performing laboratory tests, replacing fluids, and instituting Wangenstein suction by way of a Levine tube.

Since 1937 we have utilized a sub-costal incision. With this incision there has been less wound pain, less inhibition of cough, and hence fewer pulmonary complications. Since 1930, perforations have been closed with linen, silk or catgut sutures tied over a pedicle or a free omental graft as advocated by the late Roscoe

Graham. Of the 170 patients presented in this series sixty-four developed a total of 72 post-operative complications, an incidence of thirty-eight per cent. In a previous report, the incidence of such complications was 50%. This reduction is in part due to the use of antibiotics.

It is interesting to note that the incidence of wound complication in those patients drained down to the peritoneum was three per cent, where as in sixty-seven cases in which the wound was not drained the incidence was sixteen per cent. Of the 170 cases of perforated peptic ulcer admitted to the Roosevelt Hospital during this period there were seventeen deaths, an overall mortality of ten per cent. Generalized peritonitis is still one of the major factors causing death, thirty-eight per cent; but that it is now second to cardiac complications which account for forty-five per cent. In general, the deaths were more frequent the longer standing the perforation and the older the individual suffering the perforation.

Forty-four per cent of those patients followed for a period of one year or more were without symptoms; fourteen per cent had symptoms controlled by diet; and thirty per cent have required additional surgery.

Massive Hemorrhage from the Upper Gastro-Intestinal Tract

Massive hemorrhage from the gastroduodenal tract is truly an emergent situation and is receiving much consideration at the present time; for prompt surgical intervention may offer the best opportunity for survival.

Much confusion that has arisen stems from the vagaries offered as to what constitutes massive hemorrhage. Only those patients who demonstrate sudden weakness, dizziness, or syncope, followed immediately and almost invariably by the vomiting of a large amount of blood or a loose tarry stool or both should be included in this group. The patient is pale, cold, perspiring, slightly cyanotic, restless, and complaining of thirst. The pulse is weak and rapid and the blood pressure is below 90mm/hg systolic. These constitute the most rigid criteria and the situation offers immediate threat to life. It is significant to note that chronic duodenal ulcer heads the list, accounting for sixty-five per cent of all patients. Chronic gastric ulcer was responsible for 9.3 per cent.

Acute gastritis was the underlying factor in eleven per cent. Gastric carcinoma was one of the rarer causes, occurring in 2.3 per cent. Marginal ulcer was the etiological factor in two per cent. Ruptured esophageal varices a factor in 7.6 per cent. No demonstrable cause was found in 3.5 per cent. It is important to note that in nearly 80 per cent of all patients with massive gastro-intestinal hemorrhage from its upper levels that peptic ulceration or carcinoma was the etiological factor.

The incidence of hemorrhage reaches its peak during the fifth decade and of importance is the fact that seven-tenths of all cases of massive hemorrhage from the upper gastro-duodenal tract occur after the age of forty years. Not only does the incidence of massive hemorrhage increase after forty-five years, but also the seriousness of this hemorrhage which has been attested to by many. Reports indicate that between twenty and forty per cent will die and that of all deaths from hemorrhage that 95% are in this older group.

Recurrent hemorrhages are significantly more dangerous than the initial one.

With these factors in mind we have arrived at the following criteria for surgery in Massive Hemorrhage from the Upper Gastro-Intestinal Tract. Patients of 50 years of age or more who continue to bleed after a period of conservative management, in the younger age group after 48 hours, are advised immediate surgery. Recurrence of bleeding in the older age group is dangerous. Those patients in the hospital who are convalescing from a recent hemorrhage and begin to bleed again in the hospital while under strict management are also advised surgery. Concomitant bleeding and perforation and/or carcinoma are obvious indications.

We have had a total of 145 cases who met the criteria previously described. Ninety-five of these were treated conservatively with 15 deaths, a mortality rate of 16 per cent. Of those individuals operated on as a desperation attempt to salvage, our experience was six deaths in nine cases, a mortality rate of 66 per cent. In those individuals operated on in accordance with our criteria for surgery the mortality rate has been considerably better, 5 per cent, or two deaths in forty cases. All upper gastro-duodenal hemorrhaging cases admitted to surgical serv-

ice. This is a fascinating problem and warrants much more study.

Diverticulitis

Diverticulitis is usually thought of as a disease amenable to medical management. We know that at times it becomes a grave and immediate surgical problem. It is true that a large percentage of patients suffering from this disease are successfully treated by the physician. A remarkably small number demand surgical intervention; for the most part it is the complications of the disease that necessitate surgery.

The most frequent complication is abscess formation with local peritonitis. This condition in the absence of obstruction requires incision and drainage alone. If obstruction is present decompression by means of cecostomy or more preferably by colostomy through an upper right transverse incision is indicated.

Acute perforation of an inflamed diverticulum does occur and diffuse peritonitis ensues with rigid abdomen and diffuse tenderness. Many of this group are operated upon as emergencies with the diagnosis of acute suppurative appendicitis, acute salpingitis, or perforated peptic ulcer. Many of the smaller perforations are immediately sealed off by the omentum or loops of small intestine or even by the fatty appendages of the descending or sigmoid colon. Some are sealed off by being fixed to the parietal peritoneum, or to the bladder.

It is interesting to find what a large group of perforations was reported by the late Roscoe Graham. Of forty-four cases, there were eleven cases or 25% which had perforated abruptly and which necessitated emergency surgery. In our group, there was a pre-operative diagnosis of acute diverticulitis with perforation made in eighteen instances. Many patients are operated upon through a McBurney incision because of the pre-operative diagnosis of acute appendicitis. If the diagnosis is found to be erroneous, the intermuscular incision is sutured and a lower left rectus incision made. I have seen instances where there had been an attempt to enlarge a McBurney incision with a Weir extension and an effort made to drain a perforation on the left side or even an attempt at the more difficult procedure of suturing the perforation. It does seem justifiable to close a perforated diverticulum by putting a free fat graft or a

pedicle one or two close in over the opening with the fatty appendages of the sigmoid colon. If this is done it would seem reasonable, particularly in the desperately ill individual, to do a caecostomy in order to decompress the proximal bowel.

Acute Fulminating Ulcerative Colitis

In the acute fulminating stage of ulcerative colitis we are frequently confronted with the so-called acute surgical abdomen. These patients are desperately ill with high elevation of temperature, tender, rigid abdomens, rapid pulse, and many extremely debilitated by massive rectal hemorrhages. In our earlier experiences some fourteen years ago, we operated upon thirteen of these patients, giving them ileostomy with a mortality rate of 53%. Needless to say, this was an untenable position. Because of this high mortality rate, we insisted that our medical conferees rehabilitate these desperately ill patients up to the point where surgery would be safer. Within the last year we have operated on six of these patients in the fulminating stage of the disease, resecting their colons and giving them ileostomies in one stage. We have felt justified in carrying out such a radical procedure, for it was the only means of controlling the threat of hemorrhage. Pressure transfusions of large amounts of blood, we feel, has added to the success of these emergency procedures.

In a small percentage of patients suffering from the chronic form of the disease, perforation of the bowel has taken place and has produced a peritonitis with the typical signs of the acute abdomen. We have in a few instances successfully closed the perforation by insertion of a fat tab over the opening, needless to say with drainage. These perforations have occurred generally in the sigmoid colon. Fortunately, the symptoms were so severe to warrant immediate operation.

Laceration of the Small Intestine Secondary to Non-Penetrating Trauma of the Abdominal Parietes

Perforation, or laceration of the small intestine without penetration of the abdominal wall, is an unusual lesion, but one that is apt to result in disaster if not diagnosed early or operated upon promptly. This discussion will be limited only to perforations of the small intestines, excluding those of the stomach and colon,

and those based upon air blast, or pre-existing disease of the small intestine.

You will note that at the Roosevelt Hospital where we see considerable trauma that the incidence of non-penetrating trauma with laceration of the small bowel is somewhat higher than the other reported institutions, but that in general such a case is admitted to the surgical service in one of every 10 to 20,000 surgical admissions.

The type of violence necessary to cause the laceration of the small intestine varied widely, but in most cases was the result of a severe, sudden blow when the patient was not expecting it with a blunt object. Auto accidents ranked first on the list in which the patient was thrown against the steering wheel, the back of the front seat, or struck by a fender. However, handles, kicks, crushing injuries, blunt blows, and falls may be responsible. It is important to remember that trauma may have been insignificant enough to have been forgotten. One of our patients struck himself in the abdomen when his hand slipped opening a bottle of champagne.

Kicks and attempt to reduce incarcerated herniae have also resulted in perforation.

The clinical sequence following perforation in most cases is that of a rapidly developing peritonitis with sudden local pain succeeded by generalized severe prostrating abdominal pain with or without nausea or vomiting. The abdomen is tender generally with marked muscular spasm, absent peristalsis, and in 1/3 of cases absent liver dullness. In 3 of seven instances where the examination was carried out three-way films of the abdomen—40%—demonstrated free air in the peritoneal cavity.

However, in two instances in this series the initial trauma had been forgotten, there was only "soreness" in the abdominal wall, there was no other associated symptomatology and the physical findings revealed only minimal tenderness in the area of concern without spasm of the muscles. Peristalsis was present, there was liver dullness, and three-way films of the abdomen were negative for free air. These two patients demonstrated so little that they were discharged from the Accident Room only to return 6 and 12 hours later with the complete picture described above. Those patients were not

perforated at the initial examination and were found at operation to have had mesenteric lacerations and laceration of the small intestine adjacent to the mesenteric attachment. It was felt that initially there was compromise of the blood supply of the involved portion of the small intestine severely traumatized at the initial injury, although the continuity remained.

As one might expect the site of perforation is at or within a short distance of a fixed portion of the small intestine. The lacerations were equally divided between the mesenteric and the anti-mesenteric side of the bowel.

Early operative intervention is necessary in these cases for if repair is carried out soon enough, less than 12 hours, the opportunity for survival is improved. When no operation is carried out the outcome is death in each instance. If the operations were carried out before 12 hours had elapsed, the operative mortality would have been 19 per cent as opposed to that carried out after 12 hours when the operative mortality was 35 per cent. In our own small series of nine cases, four of five operated after 12 hours died. Four operated on before 12 hours survived in each instance.

The mortality rate is too high and in part is due to the fact that the possibility

of perforation is not suspected or having been suspected is disregarded when the roentgen studies fail to show free air under the diaphragm. Too much time is spent in wishful observation.

Non-penetrating abdominal trauma capable of causing perforation of the small intestine is encountered in one of every 10-20,000 surgical admissions. In most cases the injury was the result of a sudden severe blow, unexpected to the abdomen, by a blunt object. Eighty per cent of the perforations occur in or not far from relatively fixed portions of the small intestine. Free air is demonstrable under the diaphragm in only 40% and this examination should be regarded with this low figure in mind. The mortality bears a definite relationship to the time of operative repair and its delay is the most important single factor in causing death. Perforation of the small intestine may be suspected when there is persistent abdominal pain, tenderness, with or without nausea or vomiting, subsequent to severe or even minor trauma to the abdomen. If these signs persist for six hours, exploratory celiotomy should be carried out. Under these circumstances reasonable suspicion, as in acute appendicitis not only justifies, but demands immediate operation. The dangers of delay are far greater than the hazards of surgery.

Ulcer and Cancer of the Stomach

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Inasmuch as there may be some doubt in the minds of many physicians regarding the relationship of ulcer of the stomach and gastric cancer, it may be well to clarify the situation in the very beginning. There are some who feel that cancer of the stomach develops from benign ulcer. The reasoning back of such a theory would appear to be sound, since cancer is known to occur in areas of chronic inflammation in other parts of the body. We do see, on occasion, an ulcerative lesion of the stomach that, on microscopic section, will show typical benign ulceration in one segment, and malignant cells in another. There are certain features in these borderline cases, however, that give

an entirely different impression. Temporary response to conservative therapy, effective in the treatment of benign ulcer of the stomach, and ulcer of the duodenum, has been observed by us in several cases that were proved to have cancer. This leads us to believe that a lesion that is primarily cancer, often develops a secondary inflammatory reaction adjacent to it. The symptoms often caused by this type of early malignant ulceration of the stomach are therefore ameliorated by conservative measures. In other words, it is my opinion that ulcerative lesions of the stomach are, from the outset, either benign or malignant. Further evidence that cancer does not develop in benign chronic ulcer of the stomach is the fact that cancer of the stomach has never been produced ex-

perimentally. It is well-known that benign ulceration can be produced by a variety of techniques.

The character of these lesions may never be accurately established as regards the sequence of events, and at this time there is no particular reason for going into the argument. That improvement in symptoms and actual healing of the inflammatory reaction can take place adjacent to cancer of the stomach, is well-established. This should settle the matter in our minds regarding the serious import of all ulcerative lesions of the stomach.

In 1939, Welch and I reviewed all of the cases of gastric ulcer treated in the Massachusetts General Hospital in the previous decade. We were amazed to find that 14% of the patients subjected to surgery under the clinical diagnosis of benign gastric ulcer, proved to have cancer. This high incidence was somewhat disturbing to us, although we were prepared to find some errors in diagnosis, based on certain specific cases that had come to our attention. Although this was accepted by a few men of large experience in this field, it came as quite a surprise to the majority. Investigation in various other clinics, however, proved that the situation was pretty much the same elsewhere as it was with us. Even with our more accurate diagnostic methods, including endoscopy and cystological examinations, there continues to be approximately a 10% error in diagnosis in our clinic.

In an effort to determine the true diagnosis pre-operatively, we reviewed all of the available factors in this group of patients. It was interesting that those patients who were thought to have benign ulcer who proved to have cancer, had just as high an acid ratio as did those whose ulcer was benign. Patients with achlorhydria, however, and ulcerative lesions of the stomach, revealed malignancy in 60% of the cases. Ulcerations of the fundus, and those of the immediate pre-pyloric region, showed a much higher incidence of malignancies than did those elsewhere in the stomach. This did not prove of as much value as one might expect, since about 50% of all gastric ulcerations occur on the lesser curvature, and in fact, it was in this region of the stomach that the majority of our diagnostic errors were made.

The size of the ulceration was not of as much significance as we expected it to be, since we have seen cancer in very small ulcers, and have found enormous ulcerations, thought to be advanced malignancy, to be entirely benign. It is, however, a fact that the lesions over 2 cm. in diameter, were much more apt to be malignant than the smaller ones. The age of the patient, and the duration of his symptoms, proved to be of considerable value in differential diagnoses. The average age of the patient with gastric ulcer coming to our clinic, was about 50 years, but we did see occasional gastric ulcerations in much younger individuals. If the patient was at mid-life or beyond, and his symptoms had existed for a period of five years or more, his lesion proved to be benign in 80% of the cases, regardless of its size or location. If, however, in the same age-group, the symptoms had been one year or less in duration, the reverse was true. In other words, a patient beyond mid-life, with a short history of indigestion, and an ulcerative lesion of his stomach, is five times as likely to have cancer as benign ulcer.

Sir Henage Ogilvie aptly stated several years ago that every restaurant should be required to display a sign bearing the inscription, "Indigestion does not begin at 40." Dyspepsia, hyperacidity, heart-burn, gaseous eructations, and acid indigestion, are all terms commonly employed by the laity. They hear their younger friends with duodenal ulcer, and their wives with gall-stones, use these phrases often, and are daily reminded by radio and press of the wonderful relief to be obtained by the use of various remedies.

Duodenal ulcer is so much more common than gastric ulcer, and the symptoms produced by these two very different lesions are so much alike that it is quite understandable how the profession have been slow in recognizing the dangers of palliative treatment of gastric ulcerations. Any patient complaining of symptoms that might indicate an ulcer of the upper gastro-intestinal tract, should have an early diagnosis made, if possible. This should be done before palliative measures are instituted. If the ulcer proves to be in the duodenum, conservative treatment can be carried out with safety, since we rarely see malignancy in the duodenum. On the other hand, if the lesion proves to be in the stomach, then the situation is

TABLE I
Mortality from Carcinoma
(U.S.P.H.S. Statistics—1948)

Carcinoma of:	Deaths	Rate/100,000
*Stomach	26,215	17.9
Colon & Intestine	22,860	15.6
Rectum	10,834	7.4
Uterus	17,120	11.7
Breast	19,162	13.1
Lungs & Bronchi	16,331	11.1

far more serious and such a patient should be followed with utmost care and persistence. Furthermore, it becomes evident that benign gastric ulcer does not respond as well to conservative treatment as does duodenal ulcer. Also, it must be pointed out that gastric resection for gastric ulcer, carries far less mortality than the same procedure done for duodenal ulcer. The reason for this is that the ulcerative scarred duodenum makes closure of that structure difficult, while a normal duodenum associated with a gastric lesion, is easily closed.

At one time I felt that duodenal ulcer was the best insurance against gastric cancer that a man could have. We have seen, however, a few instances of gastric cancer developing many years later in life after a duodenal ulcer had responded well to conservative measures. The number of instances of gastric cancer associated with duodenal ulcer, would approximate very closely the rare number of cases of cancer in the duodenum that we have observed.

Cancer of the stomach continues to lead in the causes of death from cancer anywhere in the body. Although vital statistics, as published by the U. S. Public Health Service, are probably not accurate, and are from two to three years behind schedule, comparative data is significant. Cancer of the stomach is so prevalent, so insidious in onset, and the cure-rate is so low, that it behooves every physician to utilize every means at his disposal to make an early diagnosis and to urge an early surgical extirpation of the involved structures. It is significant that patients subjected to gastrectomy, for supposedly benign ulcerative lesions, that proved under microscope to be malignant, have twice as good a chance of cure as do those who have clinical cancer of the stomach. This is further borne out by the fact that patients who have a resection, and the pathologist finds that the lymph nodes are not involved with the malignant process, have a 50% chance of cure. The over-all sal-

vage rate, however, in cancer of the stomach, is very discouraging. Only about one-half of those who appear at our hospital with cancer of the stomach, arrive early enough to undergo resection of the involved area. This includes a considerable number who were subjected to total gastrectomy with the wide removal of all lymph nodes available, the adjacent spleen, and on occasion, the transverse colon.

TABLE II
Sex Incidence
Mortality from Gastric Carcinoma
(U.S.P.H.S. Statistics—1948)

Males	16,321
Females	9,894
Total	26,215
Ratio:	1.65/1

Out of a hundred consecutive cases that had come to our clinic with cancer of the stomach, we found that only 7 were alive and free of disease at the end of five years. Twenty-two of those patients surviving resection were alive and well at the end of five years. This is some improvement over the results obtained in the previous twenty years. There was a gradual lowering of the operative mortality and a gradual increase in the number subjected to resection. This resulted in an enormous gain in comfort and life expectancy in those who finally died of recurrence. It was thought that more radical surgery might off-set the persistent delay of six months, from onset of symptoms to hospital admission. This gain was not as spectacular as we had hoped, due largely to the inclusion in the resected groups, of many cases with widespread disease.

TABLE III
Carcinoma of Stomach
Five-Year Survivals
M. G. H. 1942-1946

	No. of Cases	Per Cent of Total
All cases	457	100
Resections	245	53
Palliative	32	7
For Cure	213	46
Operative Survivals,		
Resections for Cure	188	41
Five-year Survivals	31	7

Efforts have been made to determine feasible methods of discovering cancer of the stomach before symptoms develop.

This has been quite disappointing. Routine x-ray examinations by St. John et al, of a large number of patients without gastric symptoms, revealed a very small number of cases with gastric cancer. A series of patients beyond mid-life who had a low or absent gastric acidity, were studied by Wangenstein et al, who found a slightly higher percentage of symptomless cancers of the stomach. It hardly seems justifiable at this time to approach the situation in this manner. Until we have some form of diagnostic technique that could be applied to the population as a whole, it would seem that we would have to rely on early symptoms as our chief guide to early diagnosis. Although we frequently see advanced cancer of the stomach in patients with symptoms of a very short duration, it is a fact that on careful questioning, most of these will admit to some change in their digestive mechanism that would have warranted thorough investigation at a much earlier stage of the disease. The average delay from onset of symptoms to admission to our clinic was six months.

The burden is not wholly on the shoulders of the physician. We are faced, in this country, with a freedom for advertising that endangers the lives of a great many citizens. We know that early symptoms of indigestion, gaseous eructations, nausea, etc., are commonly attributed to so-called "acid indigestion." We also know that an early ulcerative lesion of the stomach with secondary inflammation, may be cancer, and still respond temporarily to a bland diet, alkalies, etc. We could be accused of "restraint of trade" if we attempted to institute legislation forbidding the advertising of remedies for the relief of acid indigestion, or to forbid the sale of such medicines, except on a doctor's prescription. On the other hand, rarely does a physician see a patient with a definite lesion of the stomach or the duodenum, who has not tried self-medication. The physicians themselves may be somewhat to blame, and often do not take seriously the symptoms that should lead to a thorough investigation rather than a trial period of bland diet, antacids, and belladonna. Without doubt, it would be difficult to persuade a great many patients to be thoroughly investigated when they first appeal to a doctor for help from what might be considered trivial symptoms. It is my feeling, however, that if education can be carried out in such a way that the doctor and the patient rea-

lize the importance of an early diagnosis in a gastric lesion, that we may find in future years a more happy situation. Surgery has become so safe that the operative mortality in gastric resection is extremely low. Since we have no other effective method of treatment of cancer of the stomach at this time than surgery, it would seem that a concerted effort should be made to have a higher percentage of patients with favorable gastric cancer subjected to operation.

In a large teaching hospital, such as the Massachusetts General in Boston, we find that in the five-year period from 1946 to 1950, 383 patients were admitted with gastric cancer as opposed to 324 with benign gastric ulcer. During the same interval that these data were obtained, 1681 patients with duodenal ulcer were admitted to the hospital. Some patients with supposedly benign gastric ulcer and many with ulcer of the duodenum, are not admitted to the wards, but are treated in an ambulatory fashion through the outpatient department. This is safe enough in patients with duodenal ulcer, but should be frowned upon in those with gastric ulcer. Duodenal ulcer is primarily a disease of younger adults, and does not need surgical intervention except for some complication which may develop. Gastric ulcer, on the other hand, is primarily a disease of people of mid-life or beyond. All should be treated in a hospital, and only those who have a small ulcer in a safer zone of the stomach and are in the younger age group should be treated conservatively. Even the younger patients with gastric ulcer should be very carefully followed. If their ulcer fails to heal or recurs, surgery should be offered to them. In the middle-age group, there is little reason for conservative treatment. In the first place, they do less well on conservative management than do those with duodenal ulcer; and in the second place, 10% of them have cancer and not benign ulcer. Therefore, we believe that all patients beyond mid-life with gastric ulceration, should be subjected to radical surgery as soon as proper facilities are available. This is, at the moment, the most logical course we have at our disposal to improve the results in cancer of the stomach.

There may be other factors known to us now that may further enhance the situation. These are primarily a more radical attack on the malignant process at the

time of operation. There are some advocates of routine total gastrectomy for all cases of cancer of the stomach. Unfortunately, there are definite and specific reasons to doubt the validity of this concept. It is admitted that the mortality of total gastrectomy can be greatly reduced if the favorable, as well as the unfavorable lesion is treated in this manner. If total gastrectomy is reserved for only those patients whose visible disease can be extirpated only by this method, the mortality will remain high. The nodal spread from cancer of the stomach is such that one cannot apply the same principle here that we do in cancer of the breast or lip. Nodes along the esophagus, behind the pancreas, along the superior mesenteric vessels, in the portal fissure, and along the abdominal aorta, cannot reasonably be included in a bloc dissection. We can and should, routinely remove the great omentum, the nodes of the sub-pyloric region, and those along the splenic vessels. In our experience a clean dissection of the celiac axis and its radicals has resulted in thrombosis of the hepatic artery and portal vein sufficiently often to cause us to abandon such an effort. One can include the transverse colon, the spleen, and the tail and body of the pancreas if there is obvious involvement of the nodes along the blood supply of these organs. Also, the edge of the liver, the gall bladder, and a segment of the diaphragm may be included if involved by contact disease. We do not feel that removal of separate metastatic deposits in the liver is justifiable save for diagnostic confirmation.

In addition to the increased mortality associated with total gastrectomy, we have the serious problem of morbidity. People can exist without any stomach. If they live several years, they do become adjusted to their changed condition. A few get on reasonably well from the beginning, but the majority of these people have great difficulty maintaining a comfortable

life. They have no desire for food, and the unintelligent have been known to die of starvation for this reason alone. Even if they can take sufficient food of one kind or another to live, they stay thin and are often too weak to carry on with their usual mode of life. Many of them will develop anemia, which can usually be controlled by the regular ingestion of soluble iron.

We must, therefore, balance the increase in operative mortality and the morbidity following total gastrectomy with the expected increase in cure-rate. We admit that the present salvage is low and we must do all that is reasonable and feasible to improve it. We know that patients with early cancer of the stomach, particularly those without lymph node involvement, have a 50% chance of cure. We also know that the majority of individuals who can be left with even a small segment of stomach get along very well. Furthermore, sub-total gastrectomy does, and probably always will, carry a lower operative mortality than total gastrectomy. Therefore, at this time it seems justifiable to stress first, early recognition of lesions of the stomach, brought about by educational methods among the profession and the laity; secondly, to subject patients with gastric ulceration to early surgery; and thirdly, to increase the extent of resection to include the available lymph nodes and sufficient apparently normal stomach and duodenum beyond the obvious disease, that disease is not left behind in the remaining stomach and duodenal segments.

Summary and Conclusions

- 1. Cancer of the stomach heads the list of the causes of death from cancer in all parts of the body. More people in the United States die of cancer of the stomach than are killed or die in highway accidents.
- 2. The present over-all cure-rate is about 7%. Patients with early cancer of the

TABLE IV
Carcinoma Stomach
Mortality—Resections for Cure
Mass. General Hospital

	1942-46		1947-50	
	5 Years		4 Years	
	No. of	Mortality %	No. of	Mortality %
	Cases		Cases	
Subtotal	147	3.4	123	4.1
Total	66	30.	39	15.
All Cases	213	12.	162	6.8

stomach, particularly those whose clinical diagnosis is benign ulcer and those whose lymph nodes are not involved, have a 50% chance of cure.

3. Gastric ulcer appearing benign, will prove to be cancer in approximately 10% of all patients observed. The average operative mortality for sub-total resection is about 3%.

4. Early symptoms of cancer of the stomach are similar to those occurring with benign ulcer of the stomach or duodenum. This, we believe, is due to secondary inflammation adjacent to early cancer. Ameliorization of symptoms by the regimen used in duodenal ulcer is common, and misleading. Such treatment often delays surgery until the disease is incurable.

5. Diagnosis must be established as soon as symptoms develop so that the gastric lesions can be managed in a logical manner.

6. The term "peptic" should be eliminated from our nomenclature because it delays the diagnosis of gastric cancer. We should separate in our minds the relative-

ly innocuous and more common duodenal ulcer from the serious and dangerous gastric ulcer.

7. Duodenal ulcer is primarily a medical disease, while gastric ulcer is primarily a surgical problem.

8. All gastric ulcer patients should be hospitalized. Young patients with small acute ulcer in one of the safer zones of the stomach, may be treated conservatively but should be closely followed. Patients of mid-life or beyond, should be treated by surgery without delay.

9. The operation for cancer of the stomach should be as radical as necessary to remove all available lymph nodes, a three-inch margin of apparently normal stomach beyond the lesion, and one inch of the duodenum should be eliminated.

10. Total gastrectomy should be reserved for those patients whose obvious disease process can be extirpated only by this method. The transthoracic approach often gives a better opportunity for cure than can be accomplished through the abdomen.

Bulbar and Respiratory Poliomyelitis: Early Detection and General Principles

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The causes and the therapeutics for ventilation difficulty in a poliomyelitis patient vary. It is therefore, exceedingly important to individualize each patient with careful clinical examination. Early detection and proper management of such patients may reduce the mortality somewhat. This requires individual analysis, close attention to details, and an understanding of certain general principles.

Clinical Definitions

1. SPINAL PARALYTIC POLIOMYELITIS WITH RESPIRATORY PARALYSIS: This refers to patients in whom tightness, weakness, and ultimately, paralysis of the muscles of the respiration (chiefly diaphragm and intercostal) develops, without obvious clinical involvement of the cranial nerves.

2. BULBAR POLIOMYELITIS: This is a gross clinical term which indicates recog-

nizable involvement of centers in the brain stem. In this form, the nerve nuclei, which innervate the entire musculature of the head and throat, are involved. In addition, the so-called *vital centers*, which are in the brain stem, may be involved: these include the *respiratory centers* and the *centers concerned with cardiovascular regulation*.

3. BULBO-SPINAL OR MIXED LESIONS CAUSING RESPIRATORY DIFFICULTY: When there is involvement of the muscles of respiration *per se* and, in addition, further respiratory difficulty because of *vital center* involvement, the mixed form is said to be present. *It is particularly in this group that keen individual clinical analysis is essential.*

Clinical Forms of Respiratory Distress

1. Primary disturbance of respiratory muscles (spasm, weakness, paralysis) i. e., the intercostal muscles and the diaphragm. Lesions of the cervical and thoracic seg-

From Department of Pediatrics, University of Louisville School of Medicine and the Louisville General Hospital, Kentucky. Aided by The Kentucky Child Health Foundation.

ments of the spinal cord cause direct effects upon the innervation of the muscles of respiration.

2. Disturbance of the respiratory center in the medulla. Lesions of these centers cause various *irregularities* of rate, rhythm, and depth of breathing.

3. Interference with adequate ventilation by the following direct factors:

- a. Paralysis of *pharynx* and/or *tongue*, resulting in accumulation of secretions.
- b. Involvement of the *larynx* due to (1) paralysis of the vocal cords, and (2) spasm and weakness of the laryngeal muscles. The former makes swift tracheotomy mandatory.
- c. Interference in the *trachea* and *bronchi* by aspirated secretions, saliva and vomitus.
- d. Interference of ventilation in the *lungs* from secondary pneumonia; pulmonary edema; atelectasis.
- e. Miscellaneous factors, including anxiety reactions, over-sedation; the alkalotic effects of vomiting.

As indicated above, any one patient may have a combination of the difficulties. This requires close individual analysis.

Early Recognition of Respiratory Distress

A. SYMPTOMS PRIMARILY DUE TO INVOLVEMENT OF THE BREATHING MECHANISM

1. Anxious expression.
2. Inability to talk easily without stopping for breath. This results in short, jerky, "breathless" sentences. Have patient count numbers and see how far he can go without pausing for breath.
3. Rising pulse and respiratory rate.
4. Beginning use of accessory muscles of respiration and movement of the *alae nasae*.
5. Relative immobility of the intercostal spaces, which may be segmental or complete, and may be chiefly one-sided or bilateral.
6. Paradoxical abdominal movement, indicating spasm, weakness, and paralysis of the diaphragm.
7. Inability to cough normally.

B. SYMPTOMS DUE LARGELY TO BULBAR INVOLVEMENT

1. Irregularity in rate, rhythm, and depth of respiration due to involve-

ment of respiratory centers.

2. Early signs of palatal and pharyngeal weakness. This may be elicited by noting a nasal twang when the patient is asked to say a hard consonant, as in "cookie" or "candy."
3. Inability to swallow, indicated both by accumulation of saliva in the pharynx and palpation of the throat when asking patient to swallow.
4. Deviation from the midline of uvula, palate, or tongue.
5. Gurgling due to accumulation of saliva and secretions in the throat.
6. Vomiting of material through the nose.

C. SPECIAL WARNING SIGNS

1. When there is involvement of one or both deltoid muscles, it is well to be specially alert for signs of respiratory difficulty.
2. If mild hypertension appears, one should be alert for bulbar symptoms.
3. The appearance of a lightly mottled skin on chest and abdomen when the bed clothes are removed and replaced, is suggestive of instability of the vasomotor center and early bulbar involvement.

D. OBSERVATION OF A PATIENT

Before searching specifically for the above-mentioned signs, it is advisable to remove clothing from the thorax and abdomen, and simply stand watching the patient breathe, carefully noting each respiratory effort in detail. It requires five (5) minutes of such observation, in order to observe fully all of the important details.

Two General Principles of Management

1. Clinical determination of which elements are contributing to the respiratory distress, with highly individualized treatment for each patient.

2. An air of assurance and calm is mandatory on the part of all attendants. Members of the family must also be calmed or excluded lest they communicate anxiety.

Immediate Management of Spinal Paralytic Poliomyelitis With Primary Involvement of Respiratory Muscles

1. Time should be taken to explain, if at all possible, the function of the apparatus, how it will operate, and the need for the patient to co-ordinate his breathing

with that of the mechanical respirator used, in order to "rest the chest."

2. The selection of a respirator will mean, in most instances, using some form of tank or body respirator.* (When not in use, these machines should be inspected closely twice a year for mechanical defects.)

3. If a patient has had a rapid respiratory rate, adjust the rate of the machine to correspond with this for at least the first five or 10 minutes, and then reduce the speed to 16-20 for adults and up to 28 for smaller children. Initially, the pressure gauge should be adjusted to move from plus 3 to 5 cms. to minus 12 to 15 cm. water. Subsequent frequent adjustments may be required. The rate and pressures of the machine should be observed often and recorded, as they do not always remain as set. Continued over-ventilation may produce alkalosis due to excessive blowing off of carbon dioxide.

4. If the patient has become exhausted, both by respiratory distress and the manipulation of being placed into the tank respirator, oxygen may be administered in the simplest fashion. Oxygen is more dense than air. A funnel suspended about $\frac{1}{2}$ inch over the patient's nose will often be relatively effective in delivering oxygen. Masks frequently cause excitement, and may provoke vomiting and aspiration of vomitus.

Immediate Management of "Pure" Bulbar Poliomyelitis

The guiding principles are to maintain an open airway and to avoid all risk of inhalation of saliva, food, or vomitus.

1. Frequent swift, gentle aspiration of the airway. Obtain the patient's cooperation, when possible, by appropriate explanation to him. A rigid or semi-rigid tip on a mechanical aspirator is preferred to a soft flexible one which may stimulate gagging and vomiting. *The physician should demonstrate the procedure fully and carefully before entrusting it to others.* Clear the vestibule, the sulci around the gums, and then proceed into the pharynx. The frequency of aspiration must be determined; it must not be a "routine order."

2. Position of patient should encourage pharyngeal drainage. For most of the

time the patient should lie prone, with the face to one side, or lie on one side of the body. (Fig. 1) It is important to *keep the head low*. For effective drainage, this means elevating the foot of the bed 20 to 35 degrees from the horizontal. Every three to four hours, the patient may be restored to horizontal position for 15 minutes as an aid in overcoming cerebral congestion. Precede lowering the bed to horizontal by scrupulous aspiration of the airway.

3. Maintain fluid and electrolyte requirement by hypodermoclysis and venoclysis. The latter should be given slowly, particularly if hypertension (which may occur as a result of bulbar poliomyelitis) is present. Tube feedings should be postponed, especially during the early critical days, as they may cause vomiting, and stimulate increased pharyngeal secretions.

4. Drugs are best avoided. Sedatives may mask the onset of progression of respiratory failure; atropine and its derivatives may induce drying of the tracheo-bronchial tree leading to atelectasis.

Immediate Management of the Combined Form (Bulbo-Spinal) With Respiratory Difficulty

Patients with involvement of the respiratory musculature necessitating use of a mechanical respirator, who in addition display bulbar symptomatology (v. supra), require skillful constant care. Their clinical status *may change rapidly*, and therapy must be highly individualized.

1. The respirator is used in the fashion described under spinal poliomyelitis; those machines which afford the greatest head-



Fig. 1. Illustrates head-low prone position with face to one side. This position facilitates gravity drainage of mucus.

*Equipment pools are maintained by The National Foundation for Infantile Paralysis. County representatives of the N. F. I. P. facilitate procurement of respirators on request of physicians.

low tilt are especially advantageous in this type of patient.

2. Aspiration of the mouth and pharynx are carried out as described above.

3. Oxygen administration is probably of value in all such patients. The funnel device described above may be used. Alternately, oxygen may be given intranasally via catheter, the gas being made to bubble through warm water for humidification. (Nasal oxygen catheters are often inserted too far; measure the distance from nasal tip to tragus of ear, and subtract $1\frac{1}{2}$ inches in adults and 1 inch in children.)

4. Avoid tube feedings and oral fluids during the critical early days of this part of the illness; maintain the fluid and electrolyte needs parenterally.

5. If the patient's respiration is suitably adjusted to the mechanical respirator, the judicious use of sedatives for the extremely anxious patient may be permissible.

General Medical Supervision During The Early Critical Stages

1. Recognize and correct bladder retention if present. This is not uncommon, and it is distressing. Catheterization, either indwelling or intermittent, is traumatic and carries some risk of infection. If voluntary voiding cannot be initiated, a therapeutic trial of Furfurthide (N. N. R.) should be made: 5 to 10 mgm. orally, or 2.5 to 5 mgm. by hypodermic injection. This is a parasympathetic stimulant. If unpleasant side effects occur, the drug may have to be omitted. If indwelling or frequent intermittent catheterization is required, urinary tract chemoprophylaxis, e. g., a soluble sulfonamide, is desirable.

2. Pulmonary complications, viz., aspiration-atelectasis and pneumonitis. Frequent turning and movement of the patient should be employed. Coughing should be encouraged; often the patients need instruction, in order that they may learn to cough during the passive expiratory cycle of the respirator. An antibiotic of a wide anti-infectious spectrum should be given to all of these patients as long as the danger of aspiration, bronchopneumonia, or atelectasis remains.

3. Psychological complications should be anticipated, and an attempt made to prevent them even during this early critical stage. *A calm assured manner, and taking the time to reiterate reassuring statements to the patient are rewarding.*

4. Avoidance of decubitus areas requires good skin care.

Observation and Follow-up Care of Poliomyelitis Patients With Respiratory Disease

For the Bulbar Symptoms:

1. As the need for frequent aspirations diminishes, the patient may be kept in the horizontal position for longer intervals.

2. When the patient no longer requires the head-low position to facilitate drainage, small amounts of water and carbonated beverages may be offered, first dropperfuls, then spoonfuls, then gradually increasing the amount. It is best to avoid milk products as long as there is any increased secretion in the throat.

3. Only when the patient begins to show signs of being able to swallow again should tube feedings be considered. Until then, make up the fluid and electrolyte needs parenterally.

4. Difficulty in swallowing may be very fleeting, and disappear several days after its appearance. It is advisable, however, to avoid over-early feedings. Permanent residual weakness in swallowing is extremely rare.

For the Patient Requiring Mechanical Artificial Respiration

1. If the patient has been receiving oxygen therapy, terminate it and observe for any ill effects, i. e., rise in pulse, change in color, movement of alae nasae, anxiety or any subjective complaints not previously present. If patient's oxygen therapy has been by funnel, leave this in place, but turn off the tank at first. If well tolerated, remove funnel, praising the progress of the patient. Encouragement is a potent therapeutic tool with these patients.

2. Without the patient's knowledge, e. g., when he is asleep, reduce the respirator's pressure and see if this causes distress in terms of beginning movement of alae nasae or restlessness.

3. Encourage the patient to take a few independent breaths short of causing obvious fatigue. Try this maneuver from the first day that the patient is in the respirator, even if only for a few seconds. (It is best to disengage and slide the carriage out but leave the motor running.)

4. No routine can be outlined for progressive weaning of the patient from his respirator. The patient should be encouraged to increase his periods of inde-

pendent breathing, but an "endurance contest" causing fatigue is to be avoided.

5. The psychologic attitudes of all people around a patient in a mechanical respirator are of extreme importance. Some patients progress better in a competitive environment. For these there are two suggestions: (a) posting a simple "achievement chart," noting how long and how often the patient can breathe independently each day; and (b) grouping a number of respirator patients together when they are well enough to be moved from one hospital to a "center."

Additional Equipment

Certain items of equipment which were of some help during an outbreak of acute anterior poliomyelitis in Louisville during 1950 are enumerated and described. This equipment has not come into universal use.

1. **CHEST RESPIRATORS:** Designed to fit over the thorax in cuirass fashion. In those patients who can tolerate them, general nursing and medical care are facilitated by ease of access to the patient. (Fig. 2.)



Fig. 2. Chest respirator for artificial respiration. One machine can serve two patients simultaneously.

2. **POSITIVE PRESSURE DOME ATTACHED TO TANK RESPIRATOR:** This is placed over the patient's head and neck, permitting the carriage to be disengaged and pulled out. Ready access to the trunk and extremities is thus afforded. (Fig 3.)

3. **ELECTROPHRENIC RESPIRATOR:** This operates on the principle of providing a rhythmic electrical stimulus to the phrenic



Fig. 3. Dome in place, carriage of respirator is disengaged. Note ease and care of patient.

nerve. Contact is made percutaneously in the neck, and dysrhythmic breathing due to involvement of the respiratory center(s) is abolished. (Fig. 4.)

4. **OSCILLATING BEDS:** The principle of electronically operated oscillating beds is that, as the head and shoulders are elevated, the weight of the abdominal viscera pulls down the diaphragm rhythmically. The speed can be adjusted to any desired respiratory rate. These beds have limited use; but thus far, they have been regarded as useful *initially* for patients with mild difficulty in the muscles of respiration. They are also apparently useful in *weaning* patients from tank and chest respirators more rapidly. Empirically they offer the additional advantage of preventing vascular stasis as in the lungs, and of overcoming the complications of prolonged immobilization, such as skeletal



Fig. 4. Electrophrenic respirator in use. Note application of finger-electrode to motor-point of the phrenic nerve.

decalcification and urinary tract stasis. (Fig. 5.)

Tracheotomy in Poliomyelitis

The indications and the principles concerned here are identical with those in any other acute infection.



Fig. 5. Electronically controlled rocking bed. Rate and depth of excursion can be adjusted.

1. It is done when there is no other reasonable way to ensure maintenance of an adequate ingress and egress of air, without exhausting the patient.

2. Its purpose is to bypass obstruction in the pharyngeal and supra-glottic regions. It does not assist in any way the patient whose chief difficulty is weakness of the respiratory muscles.

3. The operation is traumatic and is not undertaken lightly. Its complications may include hemorrhage, subcutaneous and interstitial emphysema, and pneumothorax. Subsequent drying and crusting of tracheobronchial secretions may occur and favor the development of atelectasis.

4. The prevailing circumstances may determine the decision to do tracheotomy. Thus, if skilled nursing and medical attention are available, pharyngeal aspiration and postural drainage may be adequate. In epidemic circumstances with large numbers of bulbar patients and inadequate numbers of skilled personnel, a tracheotomy may become the lesser of two evils.

Certain Types of Congenital Heart Disease Amenable to Surgery

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During the last decade amazing progress has been achieved in the field of congenital anomalies of the heart and great vessels. Much of the credit for this progress is due to the untiring efforts of the late Maude Abbott whose thorough and comprehensive investigations brought a hitherto complicated and obscure subject into the light of clearer understanding. Other workers have given invaluable impetus to the study of congenital cardiovascular anomalies. To mention only a few: Helen B. Taussig, when she first took up her work in the Cardiac Clinic at the Harriet Lane Home of the Johns Hopkins Hospital remarked that she intended to ignore the study of the cardiac malformations because they were the hopeless finalities in which the physician was limited to matters of general advice and prognosis¹, but later she, with Dr. Blalock, studied the physiologic changes that resulted from abnormal function in patients with pulmonic stenosis, proved their theories and developed an operation

for relief of a larger majority of patients in this group. Gross, a pioneer in the successful surgical approach to certain malformations, first operated successfully on patent ductus arteriosus and followed Craaford of Sweden for surgery of coarctation of aorta. In the realm of physiological studies of the heart the introduction of cardiac catheterization has been an invaluable adjunct. Forssmann, a German, in 1929 with the help of a surgical friend first introduced the method by catheterizing his own heart². In 1941 Cournand emphasized its applicability in study of certain physiologic changes occurring in various types of heart disease. Many, many others within the past decade have made outstanding contributions to this challenging and intriguing field. Before passing from this very brief historical review one must comment on the remarkable knowledge possessed by many of our illustrious predecessors of many years ago who toiled without the benefit of modern diagnostic knowledge and methods and

described with remarkable accuracy many of the congenital malformations of the cardiovascular system³.

This subject is such that it behooves every physician to be thoroughly acquainted with these anomalies that are now amenable to surgery and to be able to diagnose accurately these anomalies.

It is the purpose of this paper to discuss certain of these congenital cardiac malformations and to discuss briefly the dynamic changes observed in cardiac catheterization.

Patent Ductus Arteriosus

The ductus arteriosus is a short vessel connecting the aorta and the pulmonary artery, a shunt which is essential before birth, but which becomes unnecessary and often a menace if it fails to close off normally in the first few weeks or months of post-natal life. Of Abbott's 1,000 cases of congenital heart disease there were 263 cases of patent ductus arteriosus. Of these, 106 were uncomplicated and 157 were associated with another defect⁴. The pathological physiology is generally agreed to be a leakage or a shunt from the aorta to the pulmonary artery, because of pressure differences in these two vessels. This blood is again pumped around the lesser circulation, returned to the left auricle and the left ventricle and is again pumped out into the aorta. The volume of blood shunted from the aorta through the ductus arteriosus may be enormous. According to Eppinger, Burwell and Gross⁵, approximately 45 to 75% of the blood of the aorta was shunted through the pulmonary artery, without supplying the periphery of the body. Keys⁶ in a similar series found that it varied from 20 to 60%. It is to be remembered that the majority of patients in both groups were subjected to operation because they were incapacitated by the condition. However, the shunt is probably much less in many asymptomatic cases. Symptoms therefore, vary with the size of the shunt. In infants there may be a reversal of flow with a venous-arterial shunt during crying, sucking or coughing⁷. Such a reversal with transient or terminal cyanosis may occur also during pulmonary infections and heart failure or in cases combined with other cardiac anomalies.

The following clinical discussion applies to cases of uncomplicated patency of the ductus arteriosus.

In many, or indeed, in most cases there may be no symptoms due to the lesion. Cyanosis is absent usually, although may rarely occur with pulmonary infections and pulmonary hypertension.

Occasionally the subjects with a patent ductus are slender, undersized, underdeveloped and pale.

Physical Signs

The physical signs are characteristic. The pathognomonic sign is the Gibson Murmur which is variously described as continuous, machinery-like, train in tunnel, humming top, churning, or sawing. It is a long and rumbling murmur which occupies most of systole and diastole. There is often accentuation in late systole. The murmur may be diffuse, but is usually localized or loudest in the 2nd left interspace near the sternum which is the site of the dilated pulmonary artery. The development of the machinery murmur depends upon the relative pressure in the two circulations. Inasmuch as in infancy the difference in pressures is low only a systolic murmur may be heard. The machinery-like continuous murmur may be absent due to variations in the size and configuration of the open ductus and degree of dilatation of the pulmonary artery. A systolic thrill is usually palpable and a diastolic or continuous thrill is rarely palpable over the site of maximum intensity of the murmur. The 2nd pulmonic sound is accentuated and may be re-duplicated. This is of value in differentiating a patent ductus from pulmonic stenosis since the 2nd pulmonic sound is weak or absent in the latter condition.

Percussion may reveal a thin, rectangular area of dullness in the 2nd and 3rd left interspace (Gerhardt's dullness⁸) overlying the dilated pulmonary artery. This is inconstant or difficult to demonstrate by physical examination.

There is a high pulse pressure. The diastolic pressure is usually low and on exercise may drop to zero. Peripheral signs of aortic insufficiency with a Corrigan pulse and conspicuous capillary pulse may be present.

Fluoroscopic Studies

The x-ray and fluoroscopic studies are subject to considerable variation. The characteristic feature although not invariably present is a prominence of the pulmonary arc in the left upper portion

of the cardiac silhouette. This is known as the x-ray cap of Zinn.

Not only is the pulmonary arc prominent, but its pulsations are considerably exaggerated. The hilar shadows are also prominent both in size and pulsation (Hilar dance).

Pulmonary congestion may be present if the shunt is of considerable size.

The enlargement of the pulmonary artery and conus may be observed most readily in right oblique view. A valuable diagnostic sign occasionally present is a calcified plaque near the caudal end of the arch of the aorta in young persons⁸.

Angiocardiography

Angiocardiography usually reveals a localized dilatation of the descending aorta just below the isthmus. This characteristic bulge may be due to the infundibulum of the ductus or to a traction aneurysm of the aorta caused by the ductus. The ECG is usually normal with no axis deviation. The negative findings are important in differential diagnosis. By cardiac catheterization the blood oxygen content is found to be higher in the pulmonary artery than in the right ventricle. If the pulmonary valve is competent the right auricular and right ventricular O_2 saturation remain normal. The increased flow from the high pressure aorta into the lower pressure pulmonary artery usually increases pulmonary arterial pressure to some extent and the right ventricle must hypertrophy to meet and overcome this increased pulmonary arterial pressure. In evaluating the phenomenon of increased ventricular or pulmonary arterial pressures there are other factors to be considered: One is that of obstruction and the other is that of increase in flow⁹. In patent ductus, increase in flow is associated with some increase in pressure. In other conditions such as pulmonary artery narrowing or stenosis, the increase in pressure occurs with a lessening of flow. It is therefore important to quantitate the actual blood flow in any condition. This can be done readily by the so-called Fick principle¹⁰. According to Fick the output of the heart may be calculated by the formula:

$$\text{Cardiac output (ml/min)} = \frac{O_2 \text{ consumption}}{A-V O_2 \text{ difference}}$$

Cournand and his associates developed methods which permit direct application of this formula to man.

Samples of mixed venous blood are taken usually from the right ventricle by catheterization, and arterial samples are secured by direct puncture of a peripheral artery, usually the femoral.

The total oxygen intake is determined by use of a Douglas bag with a direct calorimeter¹⁰.

Blood flow through several circuits can therefore be determined.

$$\text{Systemic flow} = \frac{O_2 \text{ consumption}}{Cao - Cra}$$

Cao—Cra

in which Cao equals O_2 concentration in any peripheral artery and Cra equals O_2 concentration in the right auricle.

$$\text{Pulmonary Blood flow} = \frac{O_2 \text{ consumption}}{Cla - Cpa}$$

Cla—Cpa

where Cla equals O_2 concentration in left atrium and Cpa equals O_2 concentration in the pulmonary artery.

By these methods the size of the shunt can be determined.

The diagnosis of patent ductus arteriosus is based essentially on the aforementioned clinical signs and confirmation is supplied by x-rays, angio-cardiographic studies and by cardiac catheterization.

Coarctation of The Aorta

This condition has no doubt occurred since antiquity. However, this peculiar congenital malformation was not appreciated until about the middle of the 18th century. Morgagni has been quoted as having made reference in 1760 while performing an autopsy on a monk to a condition of extreme constriction of the aorta¹¹. The surgical operation for this condition was first successfully done by Craaford of Sweden on October 9, 1944. Since Bonnet's early description two forms of coarctation of the aorta have been recognized, the infantile and adult. The infantile form is characterized by diffuse involvement of the aortic isthmus from origin of the left subclavian artery to the insertion of the ductus arteriosus, and often by the association of other congenital anomalies including a patent ductus and cyanosis. The adult form is characterized by a more localized constriction at or below the insertion of the ductus¹².

The pathologic physiology in adult coarctation is due to the aortic constriction. There is usually normal flow from the right side of the heart. The blood flow to the head and upper extremities is normal or elevated. Because of the constriction,

aortic blood to lower half of the body is detoured. A striking collateral circulation develops.

Hypertension is a characteristic feature of adult type of coarctation of aorta, although symptoms may be absent. This hypertension is present in the upper extremities while the pressure in the lower extremities is lowered or absent. It is mandatory that all subjects with evidence of hypertension of upper extremities under the age of 40 be examined with coarctation of aorta in mind. The most direct method of making the diagnosis is to feel for femoral pulsation. They normally are very easily felt and in all cases in which they are diminished or absent, blood pressure readings should be taken in lower extremities.

The objective signs due to collateral circulation are often striking. Dilated tortuous collateral vessels may be visible or palpable. Most often these are situated along the inner borders of and across the scapula, in the axilla or less often along the sternum or in the epigastrium. According to Campbell and Suzman these collateral vessels are more readily observed when the patient leans forward.

Physical examination of the heart may reveal only slight enlargement to the left and downward. There is usually a moderately loud systolic murmur over the precordium, most intense at the base, but is often heard in the interscapular region usually just to the left of the vertebrae. Occasionally there may be a thrill. Murmurs may be heard over any of the dilated collateral vessels. In over 25% of cases reported by Abbott bicuspid aorta valves were found, so there may be murmurs of an associated aorta stenosis and insufficiency.

The X-ray diagnosis of coarctation of the aorta is dependent upon the detection of notching of the ribs due to enlargement and tortuosity of the intercostal arteries¹². Other X-ray manifestations are the lack of prominence of the aortic knob and some left ventricular hypertrophy.

According to Fray¹³ a pathognomonic feature is the presence of a localized defect or break in the continuity of the aortic arch on its convexity as viewed in the left anterior oblique view. This break is situated at the junction of the transverse and descending portion of the arch and corresponds to the location of the coarctation at the point of insertion of the ligamentum arteriosum. Gladinkoff empha-

sized the recognition of a dilated left subclavian artery and medial displacement of aortic arch.

Angiocardiography usually shows distinctly the site of occlusion or stenosis of aorta and is invaluable in determining the approximate length, calibre and relation to the subclavian artery as an aid in planning the surgical approach to this condition.

ECG is not diagnostic. There may be left axis deviation or left heart strain.

The possibility of coarctation of the aorta should be constantly in the mind of the physician when examining patient suspected to have essential or malignant hypertension, neurological disease or cardiac failure without any suggestion of congenital cardiac abnormality because surgical cure is possible if found early.

Tetralogy of Fallot

This syndrome is the result of a combination of a high ventricular septal defect with pulmonary stenosis, dextroposition of the aorta and right ventricular hypertrophy. Although William Hunter accurately described a case about 100 years before the publication of Fallot's report in 1888, the justification for continued use of the term is in the fact that Fallot realized the lesion could be recognized clinically¹⁴. The approach to the recognition and management of the condition has been completely revolutionized by the brilliant research of Blalock and Taussig and others and by the practical application of the knowledge gained.

Blalock - Taussig devised a procedure in which the subclavian or innominate artery is anastomosed end to side to the right or left pulmonary artery¹⁵. In the procedure of Potts, Smith and Gibson a direct side to side anastomosis is made between the aorta and pulmonary artery.

Cyanosis and clubbing of the digits of cardiac origin in adolescent or young adult life is caused by the tetralogy of Fallot in the great majority of instances. It is estimated that 75% of cyanotic children over the age of 2 are suffering from some form of tetralogy.

Dyspnea is a common symptom and is dependent upon a low degree of saturation of the arterial blood with O₂ and it usually becomes apparent when the child becomes active. Taussig has made the observation that patients with tetralogy of Fallot characteristically assume a squatting posi-

tion when they become dyspneic. She states this has diagnostic value¹.

Polycythemia, often of an intense degree, is present, and there is an increased blood volume primarily due to the increase in red cells.

The cardiac signs are usually a systolic murmur in 2nd, 3rd or 4th inter-space to the left of the sternum; a systolic thrill is often present; the pulmonic 2nd sound is either soft or absent.

As the result of pulmonary stenosis there is absence of the prominence normally produced by the conus arteriosus and pulmonary artery as seen by X-ray. In many instances there is actually a concavity in this segment of the cardiac contour. The concavity is best seen in right anterior oblique position.

The pulmonary vessels in the hilum are small and pulsations of these vessels cannot be seen. In the left anterior oblique position the pulmonary window is abnormally clear. There should be no pulmonary congestion and when present, some abnormality such as Eisenmenger's complex or transposition of the great vessels should be suspected.

The heart may be normal in size or it may be enlarged. If enlarged this will be the result of hypertrophy of the right ventricle as a consequence of which the heart is enlarged to the left, and the apex is elevated and blunted, resembling a sheep's nose. The blunting of the left contour, often associated with a transverse rectangular enlargement gives rise to the description of "coeur en sabot" (like a wooden shoe). Rarely dextroposition of aorta is suggested by X-ray.

In angiocardiology there is prompt passage of the dye from the right ventricle, with simultaneous opacification of the aorta and pulmonary artery. The aorta and all of its branches are visualized usually within 2-3 seconds after injection instead of 4 or 6 seconds as is normal. Relatively little contrast media enters the pulmonary artery as in contrast to the normal or large pulmonary artery seen in Eisenmenger complex. The electrocardiogram usually shows right axis deviation or right heart strain. The P waves are often tall and notched. If left axis deviation is present the diagnosis of tetralogy of Fallot should be doubted.

The arm to tongue and arm to lung circulation times are approximately the same.

Cardiac catheterization reveals elevation of the right ventricular pressure, with the pulmonary arterial pressure being lower than that of right ventricle; O₂ concentration in the right ventricle exceeds that of right atrium. In most cases of tetralogy of Fallot the flow in the pulmonary capillaries exceeds that of pulmonary artery indicating a significant collateral circulation¹⁶.

Accurate anatomic and physiologic estimations are invaluable aids in deciding whether or not operative interference will be helpful. Present procedures and clinical features are sufficient to properly diagnose those cyanotic congenital lesions which can be ameliorated by the creation of an artificial patent ductus arteriosus.

Summary

1. A brief historical review of congenital cardiovascular anomalies has been presented.

2. A discussion of some of these congenital cardiovascular anomalies that are amenable to surgery has been presented. Special emphasis has been placed on diagnostic criteria and important reference to cardiac catheterization has been made.

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The Cocksackie Virus

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In the summer of 1948 Dalldorf and Sickles of the New York Department of Health were investigating small epidemics of poliomyelitis in upstate New York searching for a mouse adaptable virus. From the feces of two children with paralytic disease they were able to isolate an agent which produced paralysis and muscle degeneration in suckling mice and hamsters. The virus, which displayed characteristics of a different nature from other known viruses they called the Cocksackie or C virus from the village in which the two patients lived. On further study, they found the agent in feces from Ohio, North Carolina, and in flies in Texas. Melnick and his associates of the Department of Pediatrics at Yale began to work on this problem and isolated the virus from patients with paralytic and non-paralytic conditions simulating poliomyelitis, summer grippie, and epidemic myalgia. This material was from Connecticut, Ohio, and North Carolina. In 1950 Beatrice Howett of the U. S. Public Health Service, Atlanta, Ga., isolated four different viral strains from frozen feces, blood, mouth washings, and brain and cord specimens from 97 different persons in nine states. These patients manifested variable and ill defined clinical symptoms. In adults the majority showed an influenza like picture associated with headache and muscle spasm.

Chief Characteristics

From the combined efforts of these workers a definite picture of the virus group has emerged. There are two characteristics which all members show: (1) they are pathogenic only for immature experimental animals (suckling mice and hamsters) and (2) in such animals they induce degenerative lesions of the skeletal muscles, fat pads and brains. At present they are classified into groups A and B on the basis of the pathology produced in experimental animals. Group A includes at least 10 distinct serologic types and Group B at least 3 types.

I shall go into no detail regarding the experimental techniques used in the isolation of the groups or types as that is beyond the scope of this review. They are given completely in the papers of Dalldorf, Melnick, and Howett. In brief the

suspected material is injected into suckling Swiss mice (or hamsters) by the intracerebral, intraperitoneal, or subcutaneous route. In 2 to 10 days signs of disease appear manifested by weakness in one or more extremities. Some strains of the virus produce only ataxia, while tremor of the head is characteristic of others. Wrist drop may be a striking involvement. Death usually follows for the animal within 24 hours.

Tissue Findings

On examination of the tissues, those injected with Group A virus show an extensive myositis with degeneration of the striped muscle most extensive in the limbs. Those injected with Group B virus have focal muscle lesions, often hard to find, areas of severe focal regeneration in the brain and necrosis in the fat pads between the shoulders.

The determination of specific types is done by neutralization studies and complement fixation reactions. From these studies many strains from widely separated areas at first thought to be newly discovered types by the investigators have later been found to be identical with previously known types. Nomenclature has not been standardized and it is difficult at times to know just which virus type is under discussion by various authors.

Nature of the Virus

The virus appears to be one of the smaller viruses, resembling poliomyelitis in this respect. Filtration through gradocol membranes of known porosity indicates the diameter of different types to be 15 to 23 MM. Centrifugation studies confirm this. It is resistant to ether, penicillin, streptomycin and cholormycetin: is inactivated by heating to 55° C for 30 minutes but is destroyed at 60° C for a like time. It is stable for long periods of time when stored at -20° C or -70° C, and its infectivity is preserved in 50% glycerol in ice box or room up to 70 days. Homologous immune serum prepared in animals completely neutralizes the virus but hyperimmune sera prepared against a number of other viruses have no neutralizing effect. To date, all reported virus has been obtained from material collected

during the summer and early autumn months but work is in progress to determine the incidence during the remainder of the year. The exact geographical distribution has not been determined but it has been found to be present over the eastern United States and as far west as Texas. In nature it has been found in man, in flies, and in sewerage.

At the same time that the nature of the virus has been under study clinical investigators have been studying the role of the agent in diseases of man and animals. Aside from the immature laboratory animals it appears to infect only one type of monkey, the chimpanzee, and the human. In the monkey it produces a mild grippe like infection of short duration, in the chimpanzee it produces a temporary carrier state with a rise in neutralizing antibodies in the blood. In man it has been found consistently in several types of disease.

The original virus was found during an outbreak of poliomyelitis in two paralytic cases. Since that time it has been isolated from both paralytic and non-paralytic cases. At times both the C virus and the poliomyelitis virus have been isolated from the same patient. The relationship between the two viruses is not understood. Dalldorf, experimenting with young mice, found that injection with Coxsackie virus protected the animals in some degree when they were subsequently injected with poliomyelitis virus. No similar protection has yet been proven in man.

Non-Paralytic Type

The non paralytic type is seen generally in children under ten years of age, but is occasionally seen in adolescents and young adults. These patients show a high fever, severe headache, muscle tenderness, a moderately stiff neck, and occasionally a transient muscular weakness of the extremities. After a course of 3 to 5 days the symptoms abate and the fever falls by lysis with complete recovery of the patient. This type of case in the past has been considered abortive poliomyelitis and will continue to be so considered until some easy method of virus identification is made available for general use in clinical laboratories. The virus has been found consistently in the stools and throat washings of this type of case and the neutralizing titer of the blood has been seen to in-

crease during the course of the disease in the convalescent state. Another form of the infection is a grippe-like condition with a red pharynx, fever, headache, and fleeting muscle pains, similar to "summer influenza." This type of reaction has been observed in several laboratory workers who were accidentally infected. In their cases the incubation period of the disease was between 2 and 5 days. The above conditions may be thought of as the "pseudo-poliomyelitic" group of Coxsackie disease as they were formerly felt by many observers to be due to a mild infection with that virus.

C Virus

The C virus has been isolated from cases of aseptic meningitis and from several cases of "fevers of unknown origin." The rise in titer in the blood of sample groups in epidemic areas indicates that there must also be widespread "silent" infections with few or no symptoms.

Another condition with which the C virus has been consistently associated is variously known as epidemic myalgia, epidemic pleurodynia, devil's grippe, and Bornholm's disease. Weller and his associates at Harvard studied six patients with typical pleurodynia and demonstrated the virus in all cases as well as a rise in neutralizing titer in the blood. Rouse and Plichet have reported a similar relationship in epidemics of Bornholm's disease in northern Europe.

The last specific condition in which the virus has been incriminated is a mild condition of childhood described in 1924 by Zahorsky of St. Louis and named "Herpangina." He describes the condition as follows:

Symptoms

"The disease begins suddenly with a marked febrile movement (102 - 105). Vomiting is very common, but does not persist as a rule. The child feels tired and often complains of pains in the back and extremities. Headache and pains in the back of the neck are frequently marked symptoms and lead one to suspect poliomyelitis at times. This impression is often accentuated by the tenderness of the extremities on movement. Anorexia is often annoying. Some complain of pain on deglutition.

On physical examination nothing is discovered except the characteristic appearance of the fauces.

The Throat

On inspecting the throat the diagnostic features are discovered. These are minute vesicles about the size of millet seed to a small pea situated on the anterior pillars of the fauces, or along the free margin of the soft palate. These vesicles are occasionally discovered on the posterior part of the buccal mucous membrane or the roof of the mouth. Much more frequently the blisters are found on the tonsil itself or on the pharyngeal mucous membrane.

The vesicle seems to begin as a small papule which undergoes vesiculation in 24 hours. This often ruptures and leaves an ulcer having a punched-out appearance and surrounded by a distinct inflammatory areola about the size of a pea. The ulcer often becomes covered with a thin exudate and its edges are undermined. It differs thus from the superficial erosions of the ulcerative stomatitis.

The lesions are not usually very numerous, two to six being most frequently seen. In one case I counted fourteen.

Associated with these vesicles a marked general angina is present. The tonsils in most cases show considerable inflammatory reaction and a slight pultaceous exudate often protrudes from the tonsils. Indeed, many cases are mistaken for a follicular tonsillitis on superficial examination. The blood shows a slight leucocytosis.

Course of the Disease

The fever continues irregularly for 2 to 4 days and drops by lysis. The other symptoms disappear with the fall in temperature. The ulcers may persist for several days longer and often show a slight scarring after healing. There are no complications or sequelae. A permanent immunity seems to follow this infection since I have not encountered a second attack."

During the summer of 1950, Huebner, Cole, Beeman, Bell, and Peers of Bethesda, Maryland, observed six cases of this condition in a suburb of Washington, D.C. All of the cases had been in contact with some other member of the group. They were able to isolate the C virus from all six cases and from several asymptomatic contacts. In 26 of 31 cases from metropolitan Washington they were able to demonstrate either the virus or an increase in specific antibodies in the serum. They feel that they have proven the virus to be the causative agent of this disease.

As this virus is a true virus none of the therapeutic agents at present available have any effect on it and the treatment of the conditions described above must be symptomatic.

Summary

1. The Coxsackie viruses were isolated by Dalldorf and Sickles in 1948. All members of the group are pathogenic for immature experimental animals (suckling mice and hamsters) and induce degenerative lesions of the muscles, brain, and fat pads. There have been identified Group A which includes at least ten distinct serologic types and Group B with at least three types.

2. The virus has been consistently isolated from diseases of man which resemble paralytic and non-paralytic poliomyelitis, from grippe-like conditions, from cases of aseptic meningitis, "fevers of unknown origin," epidemic pleurodemia, and herpangina.

3. No drug or antibiotic has any effect on the viruses and treatment of conditions caused by these agents is symptomatic.

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Special Article

Role of the Mobile Unit in Civil Defense

JOHN S. SPRAGUE, M. D.*

Lexington

Put just as briefly and as bluntly as possible, the role of the Mobile Unit is to provide for victims of a catastrophe, Medical Care which they need and which they do not have. Of course, we're considering only the medical aspects of Civilian Defense here; many other types of mobile units are important for other purposes.

The casualties in a certain locality or area may need medical care because of the nearby explosion of an atomic bomb or because of some other serious and extensive type of enemy activity. The reason the casualties do not have adequate medical care may be because there never was enough medical and allied personnel available to the locality to take care of as many dead, dying and injured as there could be, a few seconds after just one enemy guided missile landed more or less near its intended target. It should also be remembered that the casualties may not have adequate numbers of doctors to care for them because the doctors themselves, some or many of them, may be among the casualties.

These obvious considerations, and others which will already have occurred to you, make plain why it is not enough that each township and community, as well as each city and metropolis, should take thought and should plan for what the morrow may bring to its own immediate vicinity. Each locality must plan how and by what means it can most efficiently bring aid to other possibly stricken localities in the State, if it is to expect those localities themselves to be ready to help it in its own hour of need.

"It should be emphasized that mutual aid is a State as well as a local responsibility and that mobile support operations are entirely a State responsibility. Therefore, arrangements for medical components of mutual aid and mobile support must be made by the local civil-defense director with the State civil-defense au-

thorities." (Par. 6.24, "Health Services and Special Weapons Defense," Publication AG-11-1 of the Federal Civil Defense Administration.)

The above quotation from the so-called "Blue Book" of the medical aspects of Civilian Defense, emphasizes that it is the responsibility of the Governor of each state and those whom he appoints to represent him and to implement his wishes, to see to it that a proper and suitable organization is established or created, the purpose of which is to make possible the shifting of a certain amount of medical talent here or there over the state. The function of this group of medical people, then, is to help meet the urgent and immediate needs of the population of a locality which has been overwhelmed beyond its ability, *for the time being*, of providing its own medical care. The words in italics are very important, because it should clearly be understood that in time of crisis, when each member of a mobile unit is worrying about the possible situation at his home, the unit of which he is a member will *not* be transported to the point of assignment and left there for a prolonged period. Each locality is supposed to "take care of its own"; and if it cannot just at first, or for a few days, at least, this period during which it depends on volunteer, emergency medical personnel from outside is to be held to the barest minimum.

The policy just discussed, as well as the obvious fact that these emergency units will never be called upon to serve except in the sort of emergency from which none of us would turn away or fail to offer his utmost, assures that there will be no difficulty in completing the skeleton or outline organization of a number of such emergency units over the state. The Committee on Emergency Medical Care of the Kentucky State Medical Association feels that such an organization as suggested in paragraph 6.26 of the "Blue Book" referred to above, will be most desirable. This includes 24 persons, of whom there are 13

*Member of Committee on Emergency Medical Service K. S. M. A.

physicians, 1 oral surgeon, 2 anesthetists and 8 nurses with operating room experience.

The personnel of a unit as above will not need training in pitching tents, or drilling, or procedures other than their every day work. Their duties will be: 1)

"To stand up and be counted"—to let it be known by those in authority just who constitutes the group; and 2) To stand ready to respond quickly, as a group, in time of urgent need and on call by the Governor.

YOUR VOTE IS VITAL

Are You Eligible to Cast It?

If you have not voted in the past two years,
in order to vote in the November 4 General Election
you must register between

AUGUST 8, 1952 and SEPTEMBER 5, 1952

If your residence address has changed since you last
voted—call your registration office.

**BE SURE YOU, YOUR FAMILY AND EMPLOYEES
ARE PROPERLY REGISTERED**

Healing the human body requires your skill
Healing the body politic requires your will

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COMMITTEE EXPLAINS METHOD OF HANDLING GRIEVANCES

The Professional Relations Committee was activated by the Council of Kentucky State Medical Association some thirty months ago for the purpose of considering any grievance which the public might have against the members of the Association and undertaking the settlement of these complaints on an equitable basis, from the standpoint of both the physician and the patient.

At a recent meeting of the Committee several members expressed the fear that some members of the Association do not understand the purpose of the Committee and it was thought by the Committee that these same members are frequently reluctant to cooperate to the fullest extent, because they feel that the Committee is attempting to legislate certain changes into their system of practice.

The Committee desires to make it entirely clear that it neither has, nor seeks punitive or legislative powers. It is concerned only with maintaining a friendly and cooperative working agreement between physician and patient, and to this end the Committee offers its service by attempting to bring grievances into the light where they may be viewed and reconsidered by both parties. The Committee is of the opinion that if this can be accomplished in a spirit of fair play, an agreement satisfactory to both sides can usually be reached.

The Professional Relations Committee does not have and has never had any desire to fix a physician's fee. But in carrying out its duty, it is frequently necessary to discuss a fee with the physician whose patient has filed a complaint against him. But the fact that it is necessary to discuss this subject should not be taken by the physician as an effort on the part of this Committee to fix his charges.

The Committee itself does not undertake to force a physician to do anything even though it may feel that in a given instance he is completely in error. In such cases if all efforts of the Committee are ignored and the physician refuses to cooperate, the Committee, after a thorough study, turns its evidence over to the Council, or such other agency of the Association as may be proper for such action as it may deem necessary.

On the basis of the Committee's experience and observation, it believes that members of the Association can remove the cause for the vast majority of complaints from the public, if they will carefully follow thoughtful and considerate rules of professional and business practice. Every effort should be made to help the patient understand what is involved in the service which he has received, or is requesting. It should be constantly borne in mind that every individual has an absolute right to be familiarized with every item or service for which he is expected to pay. The department store, garage, or grocery with which the patient does business, considers it a good policy to itemize their charges. And the physician will do well to itemize his charges in so far as is practical. Certainly, he should do no less than willingly furnish an itemized statement upon request. The observance of this one thing would have prevented some of the complaints which the Committee has had to consider.

In many instances it is possible for a fee arrangement to be made before the service is rendered. This would obviate many unpleasant misunderstandings.

Finally, it should be reaffirmed that the Professional Relations Committee is an agency of the Kentucky State Medical Association, established for the sole purpose of furnishing aid in the maintenance of satisfactory relationship between the physician and his patient and that it has been the aim of this Committee to function in strict accordance with that purpose. On the other hand, it should also be emphasized that the Committee is not and was never intended to be a white washing agency set up to gloss over the complaints of patients without making a serious effort to bring about an adjustment satisfactory to both patient and physician. The work of the Committee has been made pleasant by the cooperation which it has received from a large majority of the physicians concerned and it desires to express their sincere appreciation for the courtesy which they have been shown. The Committee also wishes to assure them that the entire procedures have been held in strict confidence.

E. W. JACKSON, M. D., Chairman
Professional Relations Committee

THE PROPOSED CODE OF CONDUCT

The proposed Code of Conduct governing the practice of medicine and osteopathy in this state, as promulgated by the State Board of Health in accordance with the provisions of the Medical and Osteopathic Practice Act of 1952, is printed in full on page 361 of this issue. The Act specifies that the Code shall be based upon generally recognized principles of professional ethical conduct: each article of the proposed code is excerpted from or based upon one of the articles of the principles of Medical Ethics of the American Medical Association.

The purpose of the Code is to provide a means of controlling the occasional physician who flagrantly violates the ethics of his profession. Heretofore, expulsion from society membership was the only recourse. Since such men usually were not members of the association, or if they were, they placed little value upon their membership, there was no realistic procedure that would effectively restrain them from embarrassing the profession with their objectionable practices. Violation of the Code of Conduct after its final adoption may result in suspension, probation or revocation of the offender's license. It is planned that the State Board of Health will seek the advice and counsel of the Kentucky State Medical Association in all such actions.

It was intended by the legislature that the profession have a voice in formulating the Code. The Act requires the State Board of Health to propose a Code; to ac-

quaint each licensee with its proposals; to hold an open hearing on the Code; to notify all licensees of the time, place and date of the hearing; to consider any suggestions or criticisms that may be made at the hearing; to adopt a Code following the hearing and to file it with the Secretary of State. Any physician who may be aggrieved by the Code as filed has further protection since he may, within thirty days after the Code is filed, procure a Declaration of Rights under the Declaratory Judgment Act by filing a petition of equity with the Circuit Court of Jefferson County. Following court decision on any such petitions the Code becomes final.

The profession has the privilege and the duty of seeing that the Code that is adopted is right and just; that it is fair to the profession and that its provisions are such that it may serve the purpose for which it is intended.

Organized medicine recognizes that the time has come when, for its own protection and in self-defense, it must control the few practitioners who bring discredit upon the entire profession. The Code provides this mechanism. Kentucky's physicians are urged to study the proposed Code and to make constructive criticism of it.

The hearing on the proposed Code will be held at 9:00 A. M., Central Standard Time, September 4, 1952 in the Auditorium of the State Department of Health, 620 South Third Street, Louisville, Kentucky.

KENTUCKY'S BLUE SHIELD INDEMNITIES NOW INCLUDE RADIATION THERAPY OF MALIGNANCIES

Elsewhere in this issue the Board of Directors of Kentucky Physicians Mutual, Incorporated, announces the inclusion of indemnities for radiation therapy of malignancies when used in lieu of surgery, beginning September 1, 1952.

Again this increase of benefits is being made without raising the cost to subscribers. Allowances for x-ray therapy of major malignant tumors, such as cancer of the breast, prostate, testes, bladder, uterus, cervix or larynx, will be five dollars per treatment, not to exceed a maximum of \$150.00 during any contract year. For ra-

dium therapy a maximum of \$50.00 is allowed. When used conjunctively, the maximum allowances are \$100.00 for x-ray and \$50.00 for radium therapy. Blue Shield will pay for treatment with radioactive isotopes, with the exact indemnity determined in each case following individual consideration by the Medical Advisory Committee. When skin cancers are treated with a single massive dose the rate of five dollars per treatment does not apply and payments up to twenty-five dollars will be made.

The Plan requires proof of malignancy

prior to payment of claims and prefers that the diagnosis be substantiated by histopathological examination. When such a procedure is not feasible or possible, other competent evidence will be accepted, according to Oscar O. Miller, M. D., chairman of the committee appointed to work out the new indemnities.

Our association may take pride in the remarkable success of Kentucky's Blue Shield Plan. Its freedom from financial difficulty and its continued uninterrupted growth to a point where more than 135,000 Kentuckians enjoy its protection has been quite different from the stormy beginnings of similar young Plans in other states. Its record could have been achieved only through cooperation of the

practicing physicians and by the careful planning and thorough groundwork of the committee authorized by the House of Delegates to inaugurate the Plan. The present enrollment is proof that the public recognizes a need for Blue Shield, and its financial soundness evidences a sound actuarial structure. The latter has permitted a series of upward revisions of indemnities, all without increasing premium rates. We are informed that the Board of Directors plans to continue to broaden benefits as rapidly as is consistent with sound business practice. We sincerely congratulate those who have so capably handled this important phase of the Association's activity.

AGE AND THE A.M.A. HOUSE OF DELEGATES

Some contemporary journalists, whose political learnings are of a dubious color, boldly charge that the policies of the American Medical Association "are set by old men elected to perpetuity." Since the House of Delegates is the policy setting body of the A.M.A., these loosely made allegations are directed at it.

Retiring speaker Francis F. Borzell, M. D., Philadelphia, gave some most revealing figures in his address to the House during the recent Chicago meeting of the A.M.A. The statistics appear to dissipate the wind completely from the sails of the pinkish penmen.

The average age of members of the House is 59 and the average period of service is $5\frac{1}{2}$ years of the 188 voting members. The average age of a U. S. Senator is 57.3 and the average age of the House of Representatives is 52.8. The mean age of the Congress is about 55. When it is remembered that physicians spend from four to six years more than the average individual in getting their education, the slightly higher age of the

members of the A.M.A. House is easily accounted for.

In commenting on the average age and period of service of the members of the House, Dr. Borzell said: "It is fair to deduce from these figures that there is a healthy turnover of membership and at the same time a sound core of membership is maintained. It obviously represents a group of men elected by their constituency because of their serious interest in the objectives of organized medicine."

Another allegation is that medical education does not have any representation in the A.M.A. delegates. A check of the roll shows that 47, or 25% of the voting membership of the House, are engaged in one way or another in medical education.

Other statistical information on this year's House of Delegates shows that the 1952 members represent a total of 1084 years of service to it. There were 14 delegates serving this year for the first time. Members of all specialties were represented, including 41 internists, 21 surgeons, 18 general practitioners, and 12 urologists.

The AMA Fellowship was officially abolished by the AMA's House of Delegates at its June sessions in Chicago. Service, affiliate and honorary fellowships are to be incorporated in the membership classification. Candidates for membership in the Association will be screened by the Judicial Council prior to acceptance.

The use of audio-visual aids in the training of medical students is proving to be extremely valuable, according to the Association of American Medical Colleges. Three articles in the July issue of the Journal of Medical Education emphasize the importance of audio-visual materials in modern medical school teaching.

President's Page

The next annual meeting of the Kentucky State Medical Association will be held at the Columbia Auditorium in Louisville, October 7, 8 and 9. Experienced convention men, who attend both national and state meetings, men who analyze and improve convention operations, say that we are fortunate in having one of the best meeting places in the South.

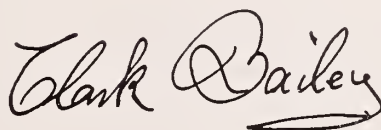
The Auditorium is close to hotels, on a good transportation system, has parking facilities nearby, and is removed from distractions often encountered at medical meetings. There is adequate space for the Scientific Assembly, the Technical Exhibits, the Scientific Exhibits, the scientific movies, reference committee rooms, temporary headquarters, press room, check rooms, and convenient rest rooms.

The Technical Exhibit at our annual meeting is recognized as one of "the largest and best of the smaller state medical associations." The exhibitor makes a most

important contribution in practical information that cannot be imparted in the office by a representative, regardless of the time given. He has the opportunity to present at first hand the most recent advances relating to the field of medicine.

The fact that the exhibitors have already bought all space available for the October meeting is indicative of a most successful convention. Without the income derived from the exhibitors it would be necessary to assess attendants about fifteen dollars each to have a meeting as good as ours. It is important that our members show their appreciation of the practical information brought to them by the exhibitors by visiting and showing interest in each exhibitor's booth.

The Technical Exhibit Committee, of which Carlisle Petty, M. D., is Chairman, together with J. P. Sanford, are to be congratulated for their work in placing our meeting on a sound footing and for their continued efforts directed at improving member-exhibitor cooperation.



PRESIDENT

ORGANIZATION SECTION

K.S.M.A. Organizes Mobile Support Groups for Civil Defense

The Committee on Emergency Medical Service, of the Kentucky State Medical Association, is making satisfactory progress in mobilizing the physicians of the state and auxiliary personnel into four mobile support groups, G. Y. Graves, M. D., Bowling Green, Chairman, said at the close of the third meeting of his committee in the past four months.

"Many physicians may be asked to sign up with one of the Civil Defense Mobile Support Groups in the near future," Dr. Graves said, in explaining that each group would be expected to recruit enough professional and technical personnel to staff a 200 bed emergency hospital.

"In order to avoid any misunderstanding, I would like to emphasize that these groups are being organized with the primary purpose of supporting the Civil Defense effort in Kentucky, where needed," Dr. Graves stated. "It is unlikely that travel outside of Kentucky will be required, certainly for not more than a brief period at a time."

Attending the meeting was Deputy Civil Defense Director Judge Gilbert White, who stated that headquarters for the four groups would be located at Paducah, Bowling Green, Louisville, and Ashland.

Clark Bailey, M. D., Harlan, President of the Association, has appointed the following physicians as medical coordinators: Henry Harris, M. D., Bowling Green; Leon Higdon, M. D., Paducah; Thomas Gudex, M. D., Louisville; and Paul A. Bryan, M. D., Ashland. In addition, a fifth medical unit is being formed at Lexington, with John S. Sprague, M. D., as coordinator. This unit will operate independently.

Dr. McCormick, Toledo Surgeon, Is New AMA President Elect

Edward J. McCormick, M. D., Toledo, defeated Francis F. Borzell, M. D., Philadelphia, by a vote of 103 to 70, to become President-Elect of the American Medical Association at the final session of the House of Delegates at the Annual Meeting in Chicago, June 12.

Dr. McCormick, who will become President at the June 1953 meeting in New York, is a

surgeon and a vigorous and active supporter of organized medicine. He has been a member of the A.M.A. Board of Trustees for the past five years, has served on the A.M.A. Council on Industrial Health and Council on Medical Service. Since 1950, he has been chairman of the Committee on Scientific Exhibits, and he is a member of the Coordinating Committee.

The President-Elect is a graduate of the St. Louis University School of Medicine, a past president of the Toledo-Lucas County Academy of Medicine, the Ohio State Medical Association and the Toledo Board of Health. He is a member of the American College of Surgery, a diplomate in the American Board of Surgery and a member of the International College of Surgeons.



DR. McCORMICK

Leo. F. Schiff, M. D., New York City, was named Vice-President. James R. Reuling, M. D., Bayside, New York, who has been serving as Vice-Speaker of the House was chosen to succeed Dr. Borzell as Speaker of the House and George F. Lull, M. D., was re-elected Secretary and General Manager.

Nominations For Annual Awards To Be Submitted By Aug. 30

Nominations for the three awards to be given by the Association at the annual meeting should be submitted to the Headquarters Office by August 30. Both individual physicians and county medical societies are eligible to submit nominations for any of the three awards described below.

The Distinguished Service Medal—Awarded on the basis of the following points: (1) Contribution to organized medicine (including membership in county society, attendance county and state, service on committees, as an officer, etc.) (2) Individual medical service, (3) Community health education and civic betterment, (4) Medical research, (5) Medical teaching, (6) Active military service. The applicant may qualify on any one, all, or any combination of

(Continued on page 352)

SCIENTIFIC PROGRAM

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THE DANIEL DRAKE MEMORIAL MEETING

COLUMBIA AUDITORIUM

* * * *

THE KENTUCKY STATE MEDICAL ASSOCIATION

Louisville, Kentucky

October 7, 8, 9, 1952

Tuesday, October 7, 1952

- 9:00 Opening of Convention
- 9:30 "Diet and Arteriosclerosis, With Special Reference to Coronary Arteriosclerosis"
Alfred Steiner, New York, New York
- 10:00 "Mitral Stenosis—Its Surgical Correction"
W. Buford Davis, Louisville, Kentucky
- 10:30 Visit the Exhibits
- 11:00 "Obstetrical Anesthesia in General Practice"
Warren F. Sergeant, Lexington, Kentucky
- 11:30 Oration in Medicine—"The General Practitioner Sees the Hypertensive Patient"
Joseph M. Bush, Mt. Sterling, Kentucky
- 12:00 Adjournment
- 2:00 "The Diagnosis of Lung Lesions"
Paul Crimm, Evansville, Indiana
- 2:30 "Carcinoma of the Cervix Uterii (Newer Ideas of Management)"
Jesshill Love, Irvin H. Sonne, Robert Graco, Louisville, Kentucky
- 3:00 Visit the Exhibits
- 3:30 "Infectious Hepatitis—Epidemiology, Diagnosis and Treatment"
Richard B. Capps, Chicago, Illinois
- 4:00 "Functional Fixation of Fractures of Upper Extremities"
William K. Massie, Lexington, Kentucky
- 4:30 Adjournment

Wednesday, October 8, 1952

- 9:00 "The Duties and Responsibilities of the Doctor and the State Medical Association in Civil Defense"
G. Y. Graves, Bowling Green, Kentucky
- 9:15 "Civil Defense Health Services and Special Weapons Defense"
Norvin Kiefer, Washington, D. C.
- 9:45 "Management of Casualties in Korea"
Col. Frank E. Hagman, Denver, Colorado
- 10:10 "The Civil Defense Blood Program"
John L. Alsever, Washington, D. C.
- 10:30 Visit the Exhibits

- 11:00 Oration in Surgery—"Geriatric Surgery"
Gaithel L. Simpson, Greenville, Kentucky
- 11:30 Adjournment
- 12:00 President's Luncheon
- 2:00 "Advances in the Surgical Management of Carcinoma of the Colon"
Eugene Bricker, St. Louis, Missouri
- 2:30 "Rural General Practice, 1952"
George Bond, Bat Cave, North Carolina
- 3:00 Visit the Exhibits
- 3:30 "The Doctor's Day in Court"
Judge L. R. Curtis, Louisville, Kentucky
- 4:00 "Practical Aspects in the Treatment of Meningitis in Children"
Robert N. McLeod, Somerset, Kentucky
- 4:30 Adjournment

Thursday, October 9, 1952

- 9:00 "Public Health Policies"
Bruce Underwood, Louisville, Kentucky
- 9:30 "Rationale of Good Control in the Treatment of Diabetes Mellitus"
Arthur R. Colwell, Chicago, Illinois
- 10:00 "Otagia"
William L. Woolfolk, Owensboro, Kentucky
- 10:30 Visit the Exhibits
- 11:00 "ACTH and Cortisone"
Cyril M. MacBryde, St. Louis, Missouri
- 11:30 "Modern Treatment of Burns"
Roy H. Moore, Louisville, Kentucky
- 12:00 Adjournment
- 2:00 "Isotopes and Radiation"
Marchall Brucer, Oak Ridge, Tennessee
- 2:30 "Endocrinology Phases of Gynecology"
W. O. Johnson, Louisville, Kentucky
- 3:00 "When a Psychiatric Case Walks Into Your Office"
Billy K. Keller, Louisville, Kentucky
- 3:30 "Surgery of the Hand"
Richard J. Rust, Newport, Kentucky
- 4:00 Adjournment

these points. Reasons for the nomination should be clearly stated.

E. M. Howard Award—Given for outstanding service rendered in behalf of organized medicine.

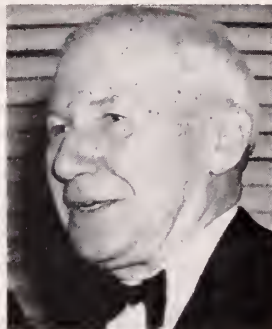
J. Watts Stovall Award—Conferred on the general practitioner adjudged the most outstanding in the state.

Following recommendations by the Council, the House of Delegates will make the final selection of the recipient of each award. The information contained in your nomination should include, if possible, biographical data, professional accomplishments, civic and community interests and other interesting material.

Fight At Polls For U. S. Liberties, New AMA Head Urges

Calling attention to ever increasing inroads of socialism in our economy and giving a prescription to end the danger, Louis Hopewell Bauer, M. D., Hempstead, N. Y., made a stirring appeal for the return to true Americanism in his inaugural address as president of the American Medical Association at the Chicago meeting.

Stating that the physicians of this country had put the brakes on the rush to socialism, Dr. Bauer said, "Sufficiently aroused, the American people can bring to a full stop the pellmell retreat from fundamental American principles. But, they cannot do it if they don't vote.



DR. BAUER

It is a shameful fact that less than 51 per cent of the eligible voters exercised their right to suffrage in the last Presidential election.

In addition to those who crowded into the ballroom of the Palmer House where the inaugural address was delivered, more than 200 radio stations on the ABC and Mutual radio networks which carried the address, heard Dr. Bauer say:

"Some of Medicine's critics have said rather naively, that politics is a dirty hands business and physicians, who belong to a clean hands profession should not enter it. How, I ask you, can politics be anything but dirty if those with clean hands stay out?"

Acknowledging the ills that beset the overall medical care problem, Dr. Bauer pointed to the many and varied activities of the A.M.A.

designed to correct the difficulties. Many of the Association's accomplishments in this direction were listed by Dr. Bauer.

"Unfortunately, there are a few physicians who are not a credit to their profession," the new president said. "They consider the practice of medicine as a means of financial gain and that alone. Such individuals should be driven out of their Medical Societies. A physician who charges exorbitant fees or who when summoned in an emergency, refuses to make the call unless assured that the patient can pay, is a disgrace to the profession."

Dr. Bauer was the luncheon speaker at the KSMA Second Annual County Society Officers Conference in Louisville in February.

Dr. Hancock Gets Appointment

J. Duffy Hancock, M. D., Louisville, one of the Kentucky State Medical Association's two delegates to the American Medical Association Annual Meeting in Chicago, was named by Speaker of the House F. F. Borzell, M. D., to serve on the Reference Committee on Industrial Health.

General Practice Scholarship Established By AAGP

The American Academy of General Practice has introduced a new program to encourage young men and women to select general practice for their medical careers.

Five young men or women will be selected annually by a specially appointed committee of the American Academy of General Practice for a scholarship for residency in general practice. The award will be given on the basis of scholarship, professional aptitude, and fitness for general practice, and will be awarded at the Academy's annual session.

The deans of five selected schools will be invited to nominate three candidates each for the award. From these candidates the committee will choose one senior student to receive the award from each school; the remaining two candidates will be designated first and second alternates.

The list of schools will be changed annually, as will the teaching hospitals offering residency training in general practice. The scholarship bestows \$1,000 each for a year's residency in general practice on the chosen students. The grant has been contributed by the Mead Johnson Company of Evansville, Indiana.

Dr. Gaines Moves Staff From Frankfort To Louisville

Frank M. Gaines, M. D., Commissioner of Mental Health, and his central office staff of 14 workers, moved their office from Frankfort to the third floor of the Annex of the State Department of Health Building in Louisville, July 1, 1952.

At the same time, Dr. Gaines announced the appointment of Richard P. Jarvis, M. D., as Assistant Commissioner. Dr. Jarvis, a native of Renton, Washington, graduated from the University of Louisville Medical School in 1945. He has just completed his training at the Norton Memorial Psychiatric Clinic.

The Department of Mental Health, created by the 1952 Legislature, supervises the four mental hospitals of the state, located at Danville, Hopkinsville, Lexington and Lyndon.

Ky. Surgeons To Attend ACS At New York Meeting, Sept. 22-26

A number of Kentucky surgeons are planning to attend the 38th annual Clinical Congress of the American College of Surgeons, September 22 through 26, at the Waldorf-Astoria in New York City.

Surgeons from many foreign countries are expected to swell the attendance to 10,000, at this meeting, which is described as the largest of its kind in the world. The College has a Fellowship of approximately 17,500.

The most recent developments in surgical and clinical techniques will be discussed as hundreds of reports will be presented by leading surgeons during the five-day session. Features of the meeting include clinics, post-graduate courses, color television, cine clinics, motion pictures, and extensive exhibits.



In attendance at the official opening of the Ephraim McDowell Memorial House, Danville, for the season, inaugurated with a tea April 29, are Mrs. Carroll Price, Chairman, Doctor's Shop, Harrodsburg; Mrs. O. Thomas Evans, Member, McDowell Furniture Committee; Mrs. Irving Gail, Chairman, Civil Defense, Lexington; Mrs. P. E. Blackerby, Co-Chairman, McDowell House Committee, Louisville; Mrs. F. E. Faulconer, great, great niece of Mrs. McDowell, Danville; Mrs. Walker Owens, Chairman, McDowell Auxiliary Committee, Mt. Vernon; Mrs. J. L. Dishman, Councilor, Fourth District, Greensburg; Mrs. John Harter, President, Woman's Auxiliary to K.S.M.A., Louisville; and Mrs. Clyde Sparks, Historian, Ashland.

Dr. Noer Succeeds Dr. Griswold As U. Of L. Surgical Chief

Rudolf J. Noer, M. D., Detroit, will succeed R. Arnold Griswold, M. D., as the head of the Department of Surgery of the University of Louisville School of Medicine, effective September 1.

Dr. Griswold, who has been the head of the department since 1938, except for a tour of duty with the Armed Services in World War II, will devote his full time to private practice in Louisville.

Dr. Noer, at the time he accepted the U. of L. appointment, was Professor of Surgery, Assistant Dean and Professor of Applied Anatomy at the Wayne University's College of Medicine. Other appointments in Detroit include Associate Surgeon, Detroit Receiving Hospital, Senior Associate Surgeon, Jennings Memorial Hospital, and consultant in surgery at the Dearborn V-A Hospital.



DR. GRISWOLD



DR. NOER

A native of Menominee, Dr. Noer graduated in medicine at the University of Pennsylvania in 1927 at the age of 23. After a two year internship in the Germantown Dispensary and Hospital, Philadelphia, he did general practice at Wabeno, Wisconsin, for three years.

In 1932, the new, U. of L. Surgical chief started a five year period of graduate training at the University of Wisconsin. In 1937 he received an appointment with Wayne University College of Medicine. He became a diplomate in the American Board of Surgery in 1938. After seeing service in World War II, Dr. Noer was separated with the rank of Lt. Colonel.

A Fellow in the American Surgical Association, and the American College of Surgeons, Dr. Noer is a member of the Wayne County, Michigan State and the American Medical Associations, the Western Surgical Association, the Central Surgical Association and the American Association of Anatomists.

Diabetic Group Hears Dr. Morse

Carlisle Morse, M. D., Louisville, Chairman of the Committee on Diabetes of the Kentucky State Medical Association, was one of the chief speakers at the annual meeting of the American Diabetic Association held at the Drake Hotel, Chicago, just prior to the opening of the American Medical Association session in June.

"Organizing a Statewide Program" was the subject discussed by Dr. Morse, who is on the A.D.A.'s National Committee on Detection and Education, at the Chicago session. Those who attended the meeting were impressed with the progress that Kentucky has made in this work.

Amendment To Kentucky Physicians Mutual Subscriber's Certificate

The following amendment to the Blue Shield subscriber's certificate has been adopted by Kentucky Physicians Mutual, Incorporated. It is being printed for the information of physicians who render such service to enrollees in the Blue Shield Plan.

AMENDMENT OF SUBSCRIBER'S CERTIFICATE

Amend Article II "BENEFITS" by adding Section 4 as follows:

RADIATION THERAPY

4. "Treatment for malignant growths by X-Ray, radium or radioactive isotopes. Payment will be made in accordance with the schedule hereto only when such treatment is used in lieu of surgery and only upon competent evidence of malignancy which shall include a positive pathological report or other evidence of malignancy."

Amend Article IV "BASIS OF SERVICE," Section 2, Subsection C to read:

MAXIMUM SERVICE

"If services included hereunder are rendered during successive periods or one continuous period of illness for the same or related causes, the total benefits for all such services under the surgical schedule to which a beneficiary shall be entitled shall not exceed one hundred and fifty (\$150) dollars during any one contract year of membership exclusive of allowance for emergency accident x-ray and anesthesia."

Amend surgical schedule by adding the following:

"RADIATION THERAPY"

(When used in lieu of surgery for proved malignancies)

An allowance will be made as follows:

X-ray, Radium or Radio Isotope treatment for Skin Cancer (not to exceed during any contract year).....\$ 25.00

Treatment for

Major Malignant Growths (such as cancer of breast, prostate, testes, bladder, uterus, cervix or larynx) as follows:

X-ray Therapy

Allowance per treatment..... 5.00
(Not to exceed \$150.00 during any contract year)

Radium Therapy (not to exceed during any contract year) 50.00

Radium Therapy in conjunction with X-ray Therapy (Maximum during any contract year):

Radium 50.00

X-ray100.00

Radio Isotopes Individual Consideration

Kentucky's 116 M.D.'s Attending AMA Chicago Meeting Listed

Approximately 116 Kentucky physicians were among the 13,162 physicians who attended the 1952 Annual Meeting of the American Medical Association in Chicago, June 8 through 13.

Leading the Kentucky contingent was Clark Bailey, M. D., Harlan, K.S.M.A. President. Delegates from this association were J. Duffy Hancock, M. D., and Bruce Underwood, M. D., both of Louisville.

Those registering from Kentucky, beginning Sunday, June 8, according to the Daily Bulletin issued by the A.M.A. are as follows:

Sunday, June 8—Paul L. Owens, Outwood; F. A. Paolini, 1st Lt. MC, Fort Campbell; Norvin L. Casper, Armond T. Gordon, Nathan Levene, Lawrence A. Davis, Arthur Clayton McCarty, and Turner A. Woodson, all of Louisville.

Monday Morning, June 9—Charles Baron, Covington; B. F. Combs, Lexington; Paul L. Garrison, Fort Knox; James Thomas Gilbert, Jr., Bowling Green; Hugh L. Houston, Murray; Vester A. Jackson, Clinton; W. H. Keeling, Bloomfield; Max D. Klein, Shelbyville; R. B. Maddox, Fort Campbell; Paul Robinson, Covington; Joseph Schickel, Burkesville; William Seth Snyder, Frankfort; John J. Sonne, Bardstown; Joseph A. Stueckinger, Lexington; Lawrence O. Toomey, Bowling Green; Allan S. Vishoot, Fort Campbell; John T. Bate, Joseph C. Bell, John S. Harter, Robert L. McClendon, and

Oscar O. Miller, all of Louisville.

Monday Afternoon, June 9—Charles B. Billington, Paducah; Boyd Candill, Lawrenceburg; W. H. Cartmell, Maysville; David L. Chamovitz, Fort Knox; W. L. Cooper, Lexington; O. T. Davis, Owensboro; James A. Freeman, Dawson Springs; Harris Isbell, Lexington; David Lonzo Jones, Fulton; George C. McClain, Benton; D. G. Miller, Jr., Morgantown; Marvin F. Miller, Lexington; Earl P. Oliver, Scottsville; Carl Pigman, Whitesburg; Owen Pigman, Whitesburg; James S. Rich, Lexington; John G. Samuels, Hickman, James H. Solomon, Kenvir; Misch Casper, William Procter Eubank, Laman A. Gray, J. Duffy Hancock, Elmer L. Henderson, Hunt B. Jones, Jesshill Love, Max P. Jones, Joshua B. Lukins, B. F. Radmacher, Ben A. Reid, James E. Ryan, L. H. South, Bruce Underwood, and Herbert Wald, all of Louisville.

Tuesday Morning, June 10—Clark Bailey, Harlan; Ralph D. Bolten, Lexington; A. D. Butterworth, Murray; A. B. Carter, Fleming; D. H. E. Keletian, Hopkinsville; John B. Floyd, Jr., Lexington; Alfred Glattauer, Brandenburg; Leon Higdon, Paducah; Coleman C. Johnson, Lexington; Wendell V. Lyon, Ashland; James L. McGraw, Fort Knox; J. Vernon Pace, Paducah; Frank L. Yarbrough, Owensboro; Charles D. Yohe, Lakeland; David G. McClure, R. O. Joplin, Marvin A. Lucas, E. L. Pirkey, R. Glen Spurling, Carlisle Morse, Marjorie Rowntree, Leonard Jerome Singerman, and Karl D. Winter, all of Louisville.

Tuesday Afternoon, June 10—Fred N. Bosilevac, Kansas City; Robert W. Boyle, Fort Thomas; Jacob Duncan Farris, Lexington; D. Y. Keith, Jr., Paducah; Edward H. Rya, Lexington; W. Clifton Richards, Glasgow; Walter B. Wildman, Fort Knox; Oren A. Beatty, Victor Paul Dalo, Charles Wm. Dowden, Stephen R. Ellis, Gracie R. Rowntree and Charles Rhea Shaw, all of Louisville.

Wednesday Morning, June 11—Marion O'Connell Crowder, Owensboro; William Lee Tyler, Jr., Owensboro; James C. Drye, Louisville; Z. S. Gierlach, Louisville; and Robert M. James, Louisville.

Wednesday Afternoon, June 11—Kenneth Walker Brumback, Cynthiana; John W. Weredith, Scottsville; Guy Morford, Owensboro; Benjamin H. Warren, Owensboro; Walter F. Williams, Ashland; and R. Arnold Griswold, Louisville.

Thursday Morning, June 12—James T. McClellan, Lexington; C. A. Morris, Covington; and Ephraim Roseman, Louisville.

Thursday Afternoon, June 12—D. W. Bardon, Lexington; Melvin J. Weber, Ludlow; D. P. Hall, Louisville; and R. N. Holbrook, Louisville.

Education Foundation Gets \$37,000 During A.M.A. Session

The American Medical Education Foundation is \$37,000 better off as a result of contributions received by the Fund and announced during the A.M.A. Chicago session, Elmer L. Henderson, M. D., Louisville, President of the Foundation, said.

The Chicago Medical Society gave \$25,000, The Woman's Auxiliary to the A.M.A. contributed \$10,000 and the American College of Radiology gave \$2,000.

Retiring President John Cline of San Francisco highly commended Dr. Henderson and the Foundation for the excellent work that had been done at a meeting of the House of Delegates. Dr. Cline said that the Foundation deserves and should have the unqualified support of all A.M.A. members.

Kentucky M.D.'s Attend Conference Of Presidents At Chicago

"If we are not prepared to work for our freedom, we don't deserve it," Allan B. Kline, Chicago, President of the American Farm Bureau Federation, told the conference of Presidents and other officers of State Medical Associations, at its annual meeting Sunday afternoon before the Annual A.M.A. sessions began in Chicago.

Mr. Kline, along with Honorable Walther H. Judd, M. D., Minneapolis, Congressman from the 5th Minnesota District, and Clarence Manion, Dean of the Law School, Notre Dame University, were the featured speakers at the session to which Clark Bailey, M. D., Harlan, was the official representative of this Association. All three speakers urged their hearers to read and re-read our Federal Constitution.

Other K.S.M.A. officials present were Delegates to the A.M.A. J. Duffy Hancock, M. D., and Bruce Underwood, M. D., both of Louisville and Hugh L. Houston, M. D., Murray, Speaker of the K.S.M.A. House of Delegates. Many felt the addresses given by these three men were outstanding among the entire week's activities.

Dr. Bailey Names Blood Group

Clark Bailey, M. D., Harlan, President of the Kentucky State Medical Association, has appointed the following members to serve on the Association Blood Bank Committee.

They are Marion Beard, M. D., Louisville, Chairman; Samuel Adams, M. D., London; Burr Atkinson, M. D., Lebanon; Luther Bach, M. D., Newport; W. P. Blackburn, M. D., Frankfort;

H. C. Burkhart, M. D., Harlan; John B. Floyd, Jr., M. D., Lexington; Hubert C. Jones, M. D., Berea; David Y. Keith, M. D., Paducah; George McClure, M. D., Danville; A. J. Miller, M. D., Louisville; W. Mountjoy Savage, M. D., Maysville; Dana Snyder, M. D., Hazard; and Paul York, M. D., Glasgow.

The American Medical Association had solicited the cooperation of this Association in having the Committee named.

Luncheon Honors Dr. Lawrence

Joseph L. Lawrence, M. D., who has been director of the A.M.A. Washington office since its inception in 1944, was honored by a luncheon attended by more than 300 of his friends, including a number of Kentuckians, held in the Palmer House on Sunday before the A.M.A. session started.

Dr. Lawrence will retire as director of the Washington office on September 1, 1952, and will be "available on a consulting basis." He will be succeeded by his deputy director, Frank Wilson, M. D. Dr. Lawrence, who is the editor of "Capitol Clinics," spoke at the K.S.M.A. First Annual County Society Officers Conference in March of 1951.

Cardiologist Receives AMA Award

George Dudley White, M. D., Boston, was voted the Distinguished Service Award of the American Medical Association by the House of Delegates at the June meeting in Chicago. Dr. White is among the best-known cardiologists in this country and his book on heart disease, recognized as one of the most outstanding, is used as a text in a number of medical schools.

AMA Publishes New Public Service Aid For Physicians

"Your Money's Worth in Health," a pamphlet designed to give the public facts on the cost of illness, which has been called medicine's top public relations problem, has been mailed to all practicing physicians in the United States, according to a report by the American Medical Association.

George F. Lull, M. D., Secretary and General Manager of the A.M.A., in speaking of the pamphlet said, "We believe that 'Your Money's Worth in Health' does such an excellent job of clarifying the rising cost of illness that medical societies will perform a public service by giving it wide distribution."

The K.S.M.A. Headquarters Office will be glad to help the physicians of this state to get as many copies of the pamphlet as they need.

State Psychiatric Assn. To Hear Dr. Rioch Sept. 27

The Kentucky Psychiatric Association will hold its annual meeting at the United States Public Health Hospital in Lexington on September 27, 1952, Irving A. Gail, M. D., Lexington, President of the Association, has announced.

David McK. Rioch, M. D., Director of Research at the Chestnut Lodge Sanitarium, Rockville, Maryland, will be the featured speaker at the banquet to be held at the new Campbell House, Lexington. Dr. Rioch's subject will be "Practice and Theory of Psychotherapy," Dr. Gail said.

V.A. Hometown Medical Care Benefits Increase In '52

The number of examinations and treatments authorized by the Veterans Administration under the Hometown Medical Care Contract between the V. A. and the Kentucky State Medical Association showed increases for the fiscal year ending 1952 as compared with 1951.

O. P. Miller, M. D., Louisville, Chief Medical Officer for the local regional office, has provided the Journal with the following information:

Fiscal Year 1952

Examinations—

Number authorized 441.....\$ 3,699.00

Treatments—

Number authorized 9147\$102,239.02

Combined Total \$105,938.02

Fiscal Year 1951

Examinations—

Number authorized 414.....\$ 3,821.50

Treatments—

Number authorized 7887.....\$ 85,068.25

Combined Total \$ 88,889.75

Ky. Doctors Get Research Grants

Kentucky has received two new research grants for projects in the fields of cancer and heart diseases, according to an announcement by the Public Health Service of the Federal Security Agency.

The grants were awarded to J. Murray Kinsman, M. D., University of Louisville, by the National Heart Institute for research on the influence of irregular heart beat on circulation and heart output. Dr. Kinsman received \$10,800 toward this work. James B. Rogers,

M. D., University of Louisville, has received \$6,000 from the National Cancer Institute for research on the rate of induced tumor growth in susceptible and nonsusceptible experimental animals.

U. Of L. Gets New Professor

Charles H. Duncan, M. D., New York, New York, became associated with the University of Louisville School of Medicine, August 1, 1952, in the Department of Internal Medicine.

Dr. Duncan received his M. D. degree from Ohio State University in 1940. He interned at General Hospital, Cincinnati, Ohio, and also took two years residency there. He received research training at New York Hospital, Cornell, and at the Ohio State University Medical School. After several years in the armed services, Dr. Duncan was discharged with the rank of Lt. Colonel.

International Surgeons Set Meet

The International College of Surgeons will hold its seventeenth annual assembly of the United States and Canadian Chapters at the Conrad Hilton Hotel, Chicago, September 2, 3, 4 and 5, according to a report by the College. The scientific program will bring together 100 or more top American and Canadian surgeons and several thousand physicians are expected to be in attendance.

Twelfth District Meets June 26

A meeting of the Twelfth Councilor District of the Kentucky State Medical Association was held at the Seven Gables Restaurant, Burnside, Kentucky, June 26, 1952, Carl Norfleet, M. D., Councilor, has announced.

Clark Bailey, M. D., Harlan, President of K.S.M.A., was the guest speaker. The scientific program, brought by Henri LeClaire, M. D., Cincinnati, was on the subject of "The Management of Cancer of the Skin."

Oscar L. May, M. D., Danville, was elected President of the District and M. C. Spradlin, M. D., Somerset, was elected Secretary.

CORRECTION

The name of Delmas Clardy, M. D., Hopkinsville, was inadvertently omitted from the list of new members of the Kentucky Surgical Society submitted to the Journal, according to Francis M. Massie, M. D., Lexington, the Society's Secretary. The original list was published on page 308 of the July Journal.

Fourth to Meet at Bardstown

The Fourth Councilor District will hold its annual dinner meeting Wednesday, July 30, 1952, at the Old Kentucky Home Country Club, Bardstown, J. I. Greenwell, M. D., Councilor, has announced.

Clark Bailey, M. D., Harlan, President of the Kentucky State Medical Association, will be the guest speaker. The scientific program will be presented by Winston Rutledge, M. D., Robert Hendon, M. D., and Malcolm Thompson, M. D., all of Louisville.

New Members Of KSMA Listed

The Association welcomes the following new members:

Campbell-Kenton—Anthony R. Giglia, Jr., Newport.

Fayette—Lloyd Mayer, Lexington.

Jefferson—Albert G. Golden, Louisville.

Perry—K. W. Cameron, Ary.

Pertinent Paragraphs

The possibility of using movies in clinics and doctors' offices as a medium for health education and entertainment is the subject of studies now underway at the University of Chicago, according to the Association of American Medical Colleges. The chief purpose of the study is to determine what types of films prove most acceptable to a general audience.

A survey of the draft status of medical faculty made recently by the Armed Forces Advisory Committee and the Association of American Medical Colleges, has shown that medical schools are in no immediate danger of losing a significantly large number of their faculty to armed forces, according to an Association spokesman. The draft classification of new faculty members should be considered by the school administrator, however, to help prevent a serious faculty shortage if increased mobilization should take place.

The Mississippi Valley Medical Society will hold its 17th Annual Meeting at the Jefferson Hotel, St. Louis, October 1, 2, and 3, 1952. There will be three full days of scientific meetings, the entire program being especially arranged to appeal to general practitioners. The President

of the MVMS is Daniel L. Sexton, M. D., Assistant Professor of Medicine, St. Louis University.

Something new has been added in the worlds of television and medicine, according to an article printed in "Today's Science and You." A combination of X-ray and TV has been created so that doctors can now study on the television screen hearts and lungs, veins and arteries in action. What's even more remarkable about this is the fact that a doctor can call in for consultation specialists from all over the country who need only travel as far as their own television sets to see the patient.

Physicians are urged to take a more active interest in the Reed-Keogh bill, a voluntary pension plan now pending in Congress, as stated in an editorial appearing in the April issue of the American Medical Association Journal. This bill, with an amendment to the Federal Internal Revenue Code, would enable self-employed professional persons and some employed persons to exclude from current taxable income amounts sufficient to finance a reasonable retirement annuity. The annuity would have to be declared as taxable income as it is received during their retired years. The American Medical Association, the American Bar Association, the American Dental Association and other groups have banded together to support this plan, rather than have the Social Security Act cover them.

In reply to a letter from Paul B. Magnuson, M. D., Chairman of the President's Commission on the Health Needs of the Nation, requesting that the A.M.A. make available pertinent information in its possession to assist the commission, the Board of Trustees of the A.M.A. told the commission it is welcome to go over any of the medical data which the A.M.A. has in its possession and which might prove helpful. However, the Board said it did not want this to be construed in any way as approval of the commission's activities, which it believes to be of political intent.

The Indiana State Medical Association's House of Delegates will meet twice a year, in accordance with a resolution adopted at the last annual session. A meeting will be called 6 months after the annual session, and will be held in some community which cannot handle the annual session. This will permit more members to see their association at work.

The 9th Annual Meeting of the American Medical Writers' Association will be held at the Jefferson Hotel, St. Louis, the afternoon and evening of Wednesday, October 1, 1952. All who are interested in medical writing, journalism or publishing are invited to attend this meeting. Arkell M. Vaughn, M. D., Loyola University, Chicago, is President of the Association.

Wallis L. Craddock, M. D., Salt Lake City, is the winner of the 12th Annual Essay Contest, Mississippi Valley Medical Society, "for the best unpublished essay on the subject of practical and applicable value to the general practitioner of Medicine." This is the second time Dr. Craddock has won the contest and he becomes the first physician to achieve this honor.

More than 1,100 workers in uranium mines and mills in Colorado, Utah, New Mexico, and Arizona have been given detailed physical examinations but no evidences of health damage from radioactivity have been revealed, according to a report by the Public Health Service of the Federal Security Agency. The examinations are part of a study of occupational health conditions in the uranium industry that has been under way since 1950, as reported by Federal Security Administrator Oscar R. Ewing.

John W. Cline, M. D., San Francisco, retiring A.M.A. President, was the nation's Number One air traveler during the year he served in office, according to a statement by an air line executive. He traveled more than 130,000 miles and delivered 84 talks, one of which was given at the President's Luncheon during the K.S.M.A. Centennial.

Olin T. West, M. D., Chicago, who served as the A. M. A. Secretary and General Manager for 23 years, died June 21 in a Nashville, Tennessee, hospital. Retiring from the A.M.A. post in 1946, he was 78 when he passed away.

A.M.A. House of Delegates actions in brief: Asked that amendments be made to the Federal Constitution placing a ceiling on governmental taxing power; voted to ask that the power of the President in making treaties be restricted; agreed to maintain organizational neutrality in the Presidential campaign, and once again endorsed the Reed-Keogh bill on income tax relief, which would encourage retirement savings.

A new series of electrical transcriptions on industrial health became available from the A.M.A.'s Bureau of Health Education on July 15 for use by local radio stations. The thirteen programs in the series point up various phases of the industrial health field. Subjects include: eye problems in industry, the aging worker, the handicapped worker, women in industry, occupational disease control, alcoholism, psychological problems of workers in relation to supervision, absenteeism control, off-the-job time, protective clothing and plant safety, family health, the white collar worker and control of air and water pollution. If you would like to have this series for your local radio station, contact the K.S.M.A. Headquarters office.

Extensive research is being made on federal medical services to dependents of servicemen and to veterans with non-service-connected disabilities, and the processing of patients between armed forces and veterans hospitals. The special subcommittee expects to submit a complete report on their findings to the A.M.A. House of Delegates in December.

One of the most important questions to be considered by the medical profession at the present time is whether or not the federal government can purchase health insurance from private carriers. It has been pointed out by both Frank Dickinson, Ph. D., A.M.A. economist, and Wendell Milliman, independent actuary, that when the federal government becomes an insured of a private insurance company, it makes the sovereign power of government subservient to a private business institution, thus creating a relationship contrary to public policy.

John V. Sullivan, M. D., Akron, Ohio, in a recent letter to A.M.A. President Louis H. Bauer, M. D., suggested that clinics and operating schedules be placed on a holiday status on election day in November. According to Dr. Sullivan, he proposed the idea because many doctors don't go to the polls due to heavy schedules at the hospitals.

The A.M.A.'s Council on Medical Education and Hospitals has delegated a special committee to study the whole status of medical internship. The committee, headed by Victor Johnson, M. D., director of the Mayo Foundation for Medical Education and Research, is made up of outstanding leaders in the hospital field throughout the United States.

County Society Reports

MUHLENBERG

A meeting of the Muhlenberg County Medical Society was held Tuesday, June 3, 1952.

The meeting was called to order by the President, Claude Wilson, M. D. The minutes of the previous meeting were read and approved.

A broad discussion was held on the principles of the operation of the UMWA Health and Welfare Fund. Members reported generally satisfactory relation with the Fund, and felt that, for what is basically an insurance scheme, the execution of forms and similar detail work was at the minimum that could be expected. Several members reported dissatisfaction with the medical certification as to the need of dental care, and felt that this was an undue burden, and had a tendency to lead to adduces.

A number of plans were made for improving the scientific program for the remainder of the year. This includes planning for the continued reception of the seminars as provided by the State Medical Society.

G. F. Brockman, M. D., Secretary

SCOTT

The Scott County Medical Society met at the John Graves Ford Memorial Hospital, Thursday, June 5, 1952, for their regular monthly meeting. The following members were present: Drs. F. W. Wilt, W. S. Allphin, H. G. Wells, E. C. Barlow, J. Campbell Cantrill and H. V. Johnson.

Representatives of the Abbott Laboratories, A. H. Hull and Jack Curtis, presented a film on Cardiac Arrhythmia which was both enjoyable and instructive.

Jesse W. Smith, M. D., of Lexington, our Consultant Radiologist, who was called in, outlined his plans for work at the local Hospital.

H. V. Johnson, M. D., Secretary

UNION

The regular meeting of the Union County Medico-Dental Society was held at Our Lady of Mercy Hospital in Morganfield, Tuesday, June 17th.

The meeting was called to order at 7:30 p. m. by the President, Wm. Humphrey, M. D. The minutes of the last meeting were read and approved.

The Secretary read a letter on Civil Defense written by G. Y. Graves, M. D., Chairman of the Committee on Emergency Medical Service,

in which he stated, at the request of Governor Lawrence W. Wetherby, the Kentucky State Medical Association, through its President, Clark Bailey, M. D., has accepted the responsibility of organizing the medical profession of Kentucky for Civil Defense. This society will do everything in its power to cooperate and make civil defense successful in Union County.

Walter L. O'Nan, M. D., Councilor for the Second District, was the guest speaker for the evening. Dr. O'Nan spoke on the importance of good doctor relations, pointing out the many ways in which we have tremendous responsibilities in our communities. He also spoke on rural health, and how important a rural health program is, and the great number of worthwhile programs that can be set up with great accomplishments, if we only let the people know the needs and then give them an opportunity to help.

Dr. O'Nan suggested that it might be possible to have several counties meet together at a central point like Henderson with P. M. Crawford, M. D., the deputy civil defense director for the state of Kentucky, and get down to basic facts on civil defense.

Members present were Drs. Carr, Conway, Humphrey, Higginson, Smith, Welker, and Puryear.

A. W. Andreason, M. D., Secretary

BOURBON

The Bourbon County Medical Society met in regular session July 22, at 7:30 P. M., in the library of the New Bourbon County Hospital with twenty members and guests present.

William S. Morgan, M. D., explained about the August 6 meeting. The society will meet in conjunction with the Mobile Cancer Unit which will spend three days in our county.

Two new members, William Cox, M. D., and Franklin Hall, M. D., young men in their first practice who opened offices here July 1, were welcomed into the Society.

J. R. Cummings, M. D., of Flemingsburg, Councilor for this district, was a guest. Dr. Cummings spoke briefly of the comparatively new Ninth District and pointed out some of its aims and obligations.

Our guest speaker was G. Y. Graves, M. D., of Bowling Green, Chairman of Committee on Emergency Medical Service for the State Medical Association.

B. N. Pittenger, M. D., Secretary

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Comparative Response to Common Methods of Therapy in Distal Colon Stasis*

Number of Hours Residue is Retained							
	24	48	72	96	120	144	168
Control (No Therapy)				○ ○ ○	○ ○ ○ ○ ○ ○ ○ ○	○ ○ ○ ○ ○ ○ ○ ○	○ ○
METAMUCIL	● ● ● ● ● ● ● ●	● ● ● ●	● ● ● ●	● ● ● ●	● ● ● ●		
Enemas	●	● ●	●	● ● ● ●	● ● ● ● ● ● ● ●	● ● ● ●	● ● ● ●
Antispasmodics				● ● ● ●	● ● ● ● ● ● ● ●	● ● ● ●	● ● ● ●
Mineral Oil		●		● ● ● ●	● ● ● ● ● ● ● ●	● ● ● ●	● ● ● ●



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*Barowsky, H.: A Roentgenographic Evaluation of the Common Measures Employed in the Treatment of Colonic Stasis, Scientific Exhibit, National Gastroenterological Association, Chicago, Sept. 17-22, 1951.

RESEARCH IN THE SERVICE OF MEDICINE **SEARLE**

Resolution Of State Board of Health Proposing a Code Of Conduct Governing The Practice Of Medicine And Osteopathy And Scheduling A Hearing Thereon

WHEREAS, Section 5 (2) (c) of Chapter 150 of the Acts of the General Assembly of Kentucky of 1952 ("Kentucky Medical and Osteopathic Practice Act of 1952") authorizes the State Board of Health to promulgate a code of conduct governing the practice of medicine and osteopathy; and

WHEREAS, Section 12 (1) of said Act provides that the Board shall, within 120 days after the effective date of the Act, adopt and promulgate said code of conduct; and

WHEREAS, Section 12 (4) of said Act provides that prior to adoption and promulgation of said code of conduct the Board shall hold a hearing, at its offices in Louisville, Jefferson County, Kentucky, on such code of conduct that the Board proposes to adopt and promulgate, and that such hearing shall be upon notice to all licensees which said notice may be effected by publication in a newspaper of general circulation in Kentucky or by publication in any official periodicals issued and circulated in Kentucky by the Kentucky State Medical Association and the Kentucky Osteopathic Medical Association;

NOW THEREFORE, BE IT RESOLVED by the State Board of Health, in meeting at Louisville, Kentucky, on June 19, 1952, that a hearing shall be conducted by the Board, in the Auditorium of the Kentucky Department of Health building, 620 South Third Street, Louisville, Kentucky, at 9:00 A. M. Central Standard Time on the 4th day of September 1952, on the following code of conduct governing the practice of medicine and osteopathy in Kentucky, which the said State Board of Health hereby proposes to adopt and promulgate pursuant to Sections 5 (2) (c), 12 (1) and 12 (4) of Chapter 150 of the 1952 Acts of the General Assembly of Kentucky, ("Kentucky Medical and Osteopathic Practice Act of 1952"):

PROPOSED CODE OF CONDUCT Governing the Practice of Medicine and Osteopathy in Kentucky

Article I

No person licensed to practice medicine or osteopathy shall advertise or permit his or her services to be advertised. Provided, that such

person may publish a brief announcement, by advertisement, cards or letters, of the opening of an office and of any change of office location or changes of office hours, and may cause to be listed in telephone directories, and classified advertising sections thereof, his or her name, address, type of practice and office hours. Modest signs on the doors, windows and walls of the licensee's office, or on the building in which he or she maintains an office, setting out his or her name and title, and location shall not be considered objectionable.

Article II

No person licensed to practice medicine or osteopathy shall neglect a patient after having accepted a case, or withdraw therefrom without giving notice to the patient, or to the patient's responsible relatives or friends, sufficiently long in advance of his withdrawal to allow them to secure another medical attendant.

Article III

No person licensed to practice medicine or osteopathy shall refuse to render aid in an emergency, if physically able and not prevented from doing so by physical circumstances beyond his control.

Article IV

No person licensed to practice medicine or osteopathy shall represent that he or she can effect radical cures by secret treatments, or by other secret remedial agents, or by methods not generally recognized, approved and employed by his profession.

Article V

No person licensed to practice medicine or osteopathy shall dispose of his professional attainments or services to any hospital, lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned.

Article VI

Each person licensed to practice medicine or osteopathy shall refrain at all times from violating, and from aiding, abetting, causing or procuring others to violate, the medical and osteopathic laws of Kentucky and all state and

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hypertension**toxemias
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Article VII

Each person licensed to practice medicine or osteopathy shall at all times cooperate with the proper authorities in the administration of sanitary laws and regulations and notify the constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities.

BE IT FURTHER RESOLVED that the Secretary of the State Board of Health is hereby directed to notify all licensees in writing of the foregoing resolution and proposed Code of Conduct at least thirty days prior to the date of the hearing set out above, and that any and all licensees, and professional organizations

representing licensees, who object to the foregoing proposed code of conduct, may appear at said hearing, in person or by counsel, and show cause, if any they can, why said code of conduct, or any part thereof, should not be adopted and promulgated by the State Board of Health as aforesaid.

* * * *

The undersigned, Bruce Underwood, M. D., Secretary of the State Board of Health, hereby certifies that the foregoing resolution was duly adopted by the State Board of Health at a meeting held on June 19, 1952, in Louisville, Jefferson County, Kentucky.

Witness my hand this the nineteenth day of June, 1952.

Bruce Underwood, M. D.

Secretary State Board of Health

News Items

Francis E. Tierney, M. D., Frankfort, resigned as Secretary-Treasurer of the Franklin County Medical Society on May 29, 1952, and will be succeeded by **W. H. Bush, M. D.**, Frankfort. Dr. Tierney has taken a position with the State Department of Health, Hartford, Connecticut.

Henry S. Collier, M. D., a 1944 graduate of the University of Louisville School of Medicine, has announced his association with **R. Arnold Griswold, M. D.**, Heyburn Building, Louisville, for the practice of surgery. Dr. Collier, who has had two years military service, received his internship and surgical training at Louisville General Hospital.

Richard T. Hudson, M. D., Heyburn Building, Louisville, announces the association of **Charles R. Hoffman, M. D.**, in the practice of Orthopaedic Surgery. Dr. Hoffman is a 1943 graduate of the University of Louisville School of Medicine. After completing his internship at Bethesda Maryland Naval Hospital, he returned to Louisville and completed his training at Norton Memorial Infirmary, Kosair Crippled Children's Hospital and Louisville General Hospital.

William E. Pugh, M. D., has become associated with **Rudy F. Vogt, M. D.**, and **Bruce B. Mitchell, M. D.**, Heyburn Building, Louisville, and will do obstetrics and gynecology. Dr. Pugh was graduated from the University of Illinois College of Medicine in 1946 and interned at Ball Memorial Hospital, Muncie, Indiana.

Oscar Hayes, M. D., formerly of Berea, is now associated with **W. O. Johnson, M. D.**, and **J. B. Marshall, M. D.**, Brown Building, Louisville, for the practice of Gynecology and Obstetrics. Dr. Hayes is a graduate of the University of Louisville School of Medicine, class of 1945. He received his internship at St. Joseph Infirmary, Louisville.

T. Ashby Woodson, M. D., Louisville, has been re-elected to a three year term to the Board of Governors of the American College of Chest Physicians from Kentucky, a position he has served in since 1946. He has been appointed to serve on the Nominating Committee, as a representative of the Board of Governors. Dr. Woodson is past president of the Kentucky Chapter of the College.

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SEPTEMBER, 1952

No. 9

OFFICERS OF KENTUCKY STATE MEDICAL ASSOCIATION



W. CLARK BAILEY, M. D.

President

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COLLEGE OF PHYSICIANS

R. HAYNES BARR, M. D.**President-Elect**

Robert Haynes Barr was born January 24, 1902, in Rome, Daviess County, Kentucky. His father, George L. Barr, M. D., practiced medicine for 45 years in Owensboro and Daviess County prior to his death in 1943. Dr. Barr was graduated from Owensboro Senior High School in 1919 and the University of Kentucky in 1923.

In September of 1923 he entered the Medical School of the University of Pennsylvania in Philadelphia, where four years later in June, 1927, he was graduated with the degree of Doctor of Medicine. He was then commissioned a First Lieutenant in the Medical Corps of the U. S. Army Reserve. After serving an interim internship at the John B. Stetson Memorial Hospital in Philadelphia, he entered Philadelphia General Hospital for a 24-month rotating internship. In 1929, he returned to Owensboro, Kentucky, and entered practice with his father, which association continued until December of 1940.

At this time Dr. Barr was ordered to active duty with the rank of Captain. Included in some of the more important assignments before being separated in January of 1946 with the rank of Colonel in the reserve, were: training medical troops for the Normandy Invasion in the supply of all medical needs, care and evacuation during military operation; formulating the medical pattern for the army of occupation and serving on the Medical Section of the Theatre General Board. He was awarded the European-African Middle East Ribbon with five battle stars and the Bronze Arrowhead of initial assault troops, the Legion of Merit, the Bronze Star with Oak Leaf Clusters and the French Croix de Guerre.

Upon resumption of his practice in Owensboro, Dr. Barr has limited his professional work to internal medicine. He is a member of the active staff, medical section, of Our Lady of Mercy Hospital and the Owensboro-Daviess County Hospital. Dr. Barr served six years as a member of the Owensboro Board of Education and served one term as Secretary and two terms as President of the Daviess County Medical Society. Mrs. Barr, who before her marriage was Helen Koehler of Philadelphia, is a Past President of the Wom-

an's Auxiliary of the Kentucky State Medical Association.

Dr. Barr has served our Association in many capacities: as a member of the Advisory Committee on Mental Hospitals, the Advisory Committee to the Editor of the Journal, the Committee on Prepayment Medical Plan and later as a director of Kentucky Physicians Mutual, Inc., the Committee on Scientific Assembly and the Board of Directors of the Kentucky Rural Medical Scholarship Fund. Dr. Barr served for three years as Chairman of the Education Sub-Committee, was a member of the Committee on Arrangements for the Centennial Meeting of 1951, has served as Councilor of the Second District, and is currently Chairman of the Committee on Arrangements for the 1952 Annual Meeting and the Public Relations Committee.

After reading the above, which actually is not a complete biographical statement on Dr. Barr, it becomes readily apparent why the House of Delegates turned to him as the 1952-53 President. It would appear that by whatever criteria the House might use in the selection of a President, Dr. Barr would qualify because of his demonstrated ability and his varied experience.

Vice-Presidents**R. W. BUSHART, M. D.****Fulton**

Dr. Bushart, a native of Fulton, was born in 1905. He received his premedical education at the University of Kentucky, from which he was graduated in 1926 with the degree of A. B., and received his M. D. degree from the University of Louisville School of Medicine in 1930. Dr. Bushart took his internship and residency training in the Tennessee General Hospital, Nashville, from 1930 to 1933.

Dr. Bushart returned to Fulton, and, with the exception of a three year period when he served in the Medical Corps of the Army of the United States, he has practiced in the Fulton Hospital since 1933.



R. Hayes Barr

PRESIDENT KENTUCKY STATE MEDICAL ASSOCIATION 1952

THOMAS VAN ZANDT GUDEX, M. D.

Louisville

Dr. Gudex was born in Louisville in 1904. He attended the University of Louisville where he received the degree of B. S. and M. D. He was graduated from the School of Medicine in 1928 and, following an internship at the Louisville General Hospital, entered general practice in 1929. He has continued to practice in Louisville except for a period of four years during World War II when he served in the U. S. Naval Reserve. At present he is the First Vice-President of the Jefferson County Medical Society. He is a member of the American Medical Association, the American Academy of General Practice, the Southern Medical Association, and the Association of American Physicians and Surgeons, and is an associate member of the American College of Chest Physicians.



KEITH P. SMITH, M. D.

Corbin



Dr. Smith was born in Whitley County in 1911. He received his M. D. degree from the University of Louisville School of Medicine in 1936 and interned at St. Elizabeth Hospital in Covington. He was discharged from the Army Air Force in 1945 with the rank of Major, after having volunteered his services in 1942 and serving in the South Pacific and as Base Flight Surgeon at Davis-Monthon Field in Tuscon.

Since 1945 he has practiced in Corbin in association with his father in the Smith Hospital, of which he is manager, and has attended several courses at the Cook County Postgraduate School of Medicine in Chicago.

Dr. Smith has the unusual honor of serving concurrently as Vice-President of the Kentucky State Medical Association and of the Kentucky Academy of General Practice. He is also a member of his county society and the American Medical Association. He is a Senior Fellow of the Southeastern Surgical Congress and participates actively in civic affairs in Corbin.

Secretary-Editor

BRUCE UNDERWOOD, M. D.

Louisville

Dr. Underwood is a native of Louisville and received his premedical and medical education in the University of Louisville. Following internship in William Beaumont General Hospital at El Paso, Texas, Dr. Underwood was engaged in public health work as a County Health Officer in Kentucky and Florida and in general practice for several years.



In July, 1948, upon the death of Dr. P. E. Blackerby, he was appointed Secretary-Editor of the Association and Commissioner of Health. He is a Diplomate of the Board of Preventive Medicine.

He continues to seek and desire the constructive criticism of each member of the Association in conducting the affairs of his office and wishes to express his appreciation to the membership for their support and cooperation during the past four years.

Treasurer

WOODFORD B. TROUTMAN, M. D.

Louisville



The Association owes to Dr. Troutman a debt of gratitude for the efficient service he has rendered the Association as its Treasurer. He was first elected to the office at the 1946 Annual Meeting and has completed six full years of service. Wise and conservative in financial affairs, Dr. Troutman continues to make a valuable contribution.

Speaker

HUGH L. HOUSTON, M. D.

Murray

The House of Delegates last year had a Speaker as its presiding officer for the first time. Formerly the President had this responsibility along with a myriad of other duties which require his attention. Acting upon the recommendation of the Committee on Con-



stitution and By-Laws, the House of Delegates relieved the President of this chore and created the offices of Speaker and Vice-Speaker. Dr. Hugh L. Houston, Murray, the immediate Past-President, was chosen and admirably performed his duties. Dr. Houston has stated that his chief purpose will be to see that each delegate is given the opportunity to fully express his views upon the matters of business that come before the House.

Vice-Speaker

CHARLES A. VANCE, M. D.

Lexington



Dr. Charles A. Vance will stand in readiness to preside over the House of Delegates if called upon to do so in the absence of the Speaker. Few members of the Association have given to its affairs the time and thought that Dr. Vance has contributed. If and when the gavel is passed to him, it will indeed be in competent hands.

Delegates to A.M.A.

J. DUFFY HANCOCK, M. D.

Louisville

Dr. Hancock received his M. D. degree from the University of Louisville School of Medicine and interned in the New York Postgraduate Hospital. He entered the practice of surgery in Louisville in 1921, in which he has continued to the present time. He has capably served the Association in numerous capacities, including a former term as delegate to the American Medical Association. Dr. Hancock is a member of the Board of Directors of Kentucky Physicians Mutual, Inc., an associate clinical professor of Surgery at the University of Louisville School of Medicine, President of the Kentucky Division of the American Cancer Society, and is a Diplomat of the American Board of Surgery and a Fellow of the American College of Surgeons. Dr. Hancock was elected delegate to the A.M.A. in 1950, and his term expires this year.



BRUCE UNDERWOOD, M. D.

Louisville

Dr. Underwood was re-elected as a delegate to the American Medical Association last year. His term will expire in 1953.

Orator in Medicine

JOSEPH M. BUSH, M. D.

Mt. Sterling



Joseph M. Bush, M. D., a native of Mt. Sterling, was born December 17, 1905. He graduated from the University of Kentucky and received his M. D. degree at the University of Louisville in 1931. Following an internship at the Louisville General Hospital, he entered the practice of medicine at Mt. Sterling where he has been since, except for a tour of duty in the Army Medical Corps from 1940 to 1945.

Upon his release from the Army, Dr. Bush took postgraduate training in x-ray at the University of Pennsylvania, Philadelphia. At present, he is president-elect of the Kentucky Chapter of the American Academy of General Practice.

Orator in Surgery

GAITHEL L. SIMPSON, M. D.

Greenville

Gaithel L. Simpson, M. D., Greenville, is a native of Muhlenburg County. Following his graduation from the University of Louisville School of Medicine in 1931 and his internship, he returned to Greenville where he has practiced since. He has been president of his County Medical Society and has served as Councilor for the old Second District and was a member of the State Board of Health.



In 1936 he was a K.S.M.A. Vice-President and has represented his County Society as its delegate to the state meeting. He is currently serving as the Chairman of the important K.S.M.A. Medical Service Committee. He is a member of the Kentucky Surgical Society, the Southeastern Surgical Society and a Fellow in the American College of Surgeons.

Col. McDonnel to Discuss Atomic Defense at Public Meeting

Colonel Gerald M. McDonnel of Washington, Chief of the Armed Forces Special Weapons Project, will be the speaker at the General Public Meeting during the Annual Session, Clark Bailey, M. D., Harlan, President of the Association, announced as the Journal goes to press. "The program will emphasize the importance of public participation in the state civil defense effort," he said.



COL. McDONNEL

Early in the year Governor Lawrence W. Wetherby asked President Bailey for the cooperation of the Medical Profession in mobilizing the State's resources for civil defense. Dr. Bailey said the Governor's request is being met in a fine way and that the Committees in charge of arranging the program at the Annual Meeting felt it was appropriate for the Association to devote the Public Session on Tuesday evening, October 7, at the Columbia Auditorium, to the promotion of the civil defense effort.

"We are fortunate in being able to present Colonel McDonnel since he has specialized in atomic medicine and has just returned from Nevada where he participated in the atomic tests recently conducted by the Army," the President said.

In addition to the seven years he has spent in his specialty of radiological defense, Colonel McDonnel has had a wide experience as a radio and television lec-

turer. His lectures are a part of the curriculum at the National Naval Medical Center at Bethesda and the Army Medical Service Graduate School at Walter Reed Hospital. The Committee feels that Dr. McDonnel will make a splendid contribution to the Tuesday night session.

Colonel McDonnel was born in 1919. He graduated from Temple University in 1943. Among the decorations he holds are Asiatic Pacific ribbon and medal, Philippine Liberation, American Theatre and World War II Victory Medal.

Recipients of the Association's three awards—The Distinguished Service Medal, The E. M. Howard Award and the J. Watts Stovall Medal for the outstanding general practitioner, will be announced at this meeting. There have been numerous nominations for these honors.

R. Haynes Barr, M. D., Owensboro, Chairman of the Committee on Arrangements and President-Elect of the Association, will preside. The Committee urges you to attend and bring your lay friends to this important and highly appropriate meeting.

Annual Dinner, Oct. 9, to Climax Busy 3-Day Meeting

Climaxing three days of hearing an unusually strong scientific program, carrying on the heavy responsibilities of the organizational phases of medicine, viewing the excellent exhibits and scientific movies that will be presented, the membership will relax at the perennially enjoyable Annual Dinner to be held in the Crystal Ball Room of the Brown Hotel at the close of the meeting, Thursday evening, October 9.

Charles E. Farnsley, Mayor of Louisville, will welcome the attendants. The feature of the meeting will be the President's Address, entitled, "Which Direction?" delivered by Clark Bailey, M. D., Harlan. You will not want to miss this splendid presentation, which is the product of many months of effort and presented by a student of the problems of organized medicine, and whose interest and understanding is widely recognized.

Other highlights of the meeting, over which Clyde C. Sparks, M. D., Ashland, Chairman of the Council, will preside, include the Charge to New Members, inaugural ceremonies of the new President, R. Haynes Barr, M. D., Owensboro, recogni-

tions and other features. A trio, composed of members of the Louisville Symphony, will provide background music.

The Committee on Arrangements urges you to purchase your tickets to the Annual Dinner as early in the meeting as possible. They may be bought at the Registration Desk or at the K.S.M.A. Booth at the Columbia Auditorium. The Committee also wants to assure the members that measures have been taken to comfortably seat all who have made reservations in advance.

Detroit Industrialist to Speak at President's Luncheon



MR. HILL

"Bulwarks" is the subject of the talk T. Russ Hill, Detroit industrialist and native Kentuckian, will give at the President's Luncheon, honoring the distinguished guests of the Association, Wednesday, October 8, in the Roof Garden of the Brown Hotel.

Born in Williamstown, Kentucky, and reared near Stamping Ground, Mr. Hill received his A. B. at Georgetown College. In World War I, he served with the Army Aviation Corps. After the war he became a Redpath Chautauqua Lecturer, and later was with the Radio Keith Orpheum Speaker Bureau. From salesman of the Jellico (Tenn.) Grocery Company, he lat-

er went to the presidency of the Hill-Lawson Company of Middlesboro, Harlan and Corbin.

At the present time, Mr. Hill is President of the Martin-Parry Corporation in Detroit, the Martin-Parry, Limited, at Toronto, the Rexair Corporation in Detroit, and is a member of the Board of Directors of the above and other companies. He is a member of the Board of Trustees of Kalamazoo College, Kalamazoo, Michigan, and formerly a member of the Kentucky Crippled Children's Commission. He is a Shriner, a member of the Elks and American Legion.

The author of nine books, Mr. Hill has a national reputation as being an outstanding speaker, and has addressed many of the larger national conventions. He mixes his humor and facts in a most persuasive and attractive fashion. His address will be one of the high points of the Annual Meeting.

Council's Effectiveness Enhanced by Executive Committee

With the expanding program of the Association, it became apparent that the load the Council, which is the interim governing body of the Association between meetings of the House of Delegates, was being called on to carry would become overwhelmingly heavy. It was found that the Council was being overburdened and that some measures should be taken to relieve the Council of some of the less important work in order that more time might be given the more important policy decisions.

With this in mind, the Council recommended a proposed change in the By-laws that was drawn up by the Committee for the Revision of the Constitution and By-Laws to the 1951 meeting of the House of Delegates. This proposal, which was enacted last fall, called for the activation of an enlarged Executive Committee, made up of the Chairman of the Council, with the Chairman of the Council being designated as the Chairman of the Executive Committee.

At the reorganization meeting of the Council, October 4, 1951, during the last day of the Annual Meeting, Clyde Sparks, M. D., Ashland, Councilor from the 13th District, was made Chairman of the Council.

(Continued on Page 370)

—:

COUNCILORS

:—

First District



J. VERNON PACE
Paducah

Second District



WALTER L. O'NAN
Henderson

Third District



DELMAS M. CLARDY
Hopkinsville

Fourth District



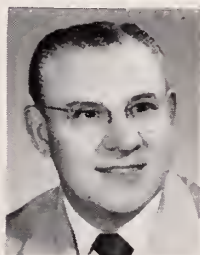
J. I. GREENWELL
New Haven

Fifth District



*R. R. SLUCHER
Buechel

Sixth District



L. O. TOOMEY
Bowling Green

Seventh District



*B. B. BAUGHMAN
Frankfort

Eighth District



EDW. B. MERSCH
Covington

Ninth District



J. R. CUMMINGS
Flemingsburg

Tenth District



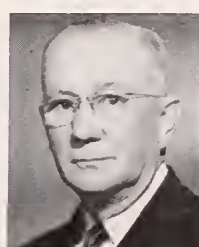
J. F. VANMETER
Lexington

Eleventh District



HUGH MAHAFFEY
Richmond

Twelfth District



CARL NORFLEET
Somerset

Thirteenth District



*C. C. SPARKS, Chm.
Ashland

Fourteenth District



PAUL B. HALL
Paintsville

Fifteenth District



EDWARD WILSON
Pineville

* Member, Executive Committee.

THE COUNCIL

(Continued from Page 368)

cil and the Executive Committee. Also elected to the Committee were B. B. Baughman, M. D., Frankfort, Councilor from the Seventh District, and R. R. Slucher, M. D., Buechel, Councilor from the Fifth District. The President, Clark Bailey, M. D., Harlan, is also a member by virtue of his office. The first meeting of the new Committee was held in Lexington in November. At this session, it was agreed that the Executive Committee would limit its action to three types: it would take positive action, make recommendations to the Council or refuse to consider a matter.

Since its activation, the Executive Committee at this writing has held six meetings and plans a seventh on September 4. As a result of these many meetings, most of the detailed work of the Council has been obviated through positive actions of the Committee. Because of the deliberations of the Committee, other matters the Council has been called on to handle have been made much easier and action has been expedited. It is responsible to the Council for all its actions. The Committee has been very conservative in its actions and its efforts have received the enthusiastic approval and appreciation of the Council.

Three new Councilors were elected at the 1951 meeting of the House. Walter L. O'Nan, M. D., Henderson, was installed as Councilor from the Second District when R. Haynes Barr, M. D., Owensboro, resigned to accept the office of President-Elect. L. O. Toomey, M. D., Bowling Green, was chosen to lead the Sixth District when the 1951 Chairman of the Council, C. C. Howard, M. D., Glasgow, indicated his desire to retire. Charles D. Cawood, M. D., Middlesboro, resigned as Councilor from the 15th District, and Edward Wilson, M. D., Pineville, was selected to take his place.

It is felt that a great percentage of the membership is not acquainted with the tremendous responsibility the Council carries. The House of Delegates is to be congratulated on the calibre of talent it has elected to the Council. The wisdom of the House's selection is demonstrated conclusively and repeatedly by the unselfish devotion, the great contribution in effort and sacrifice in time, and by its intelligent and far-sighted leadership.

Intermissions to View Technical Exhibits Are Scheduled

Taking cognizance of the important contribution the Technical Exhibits make to the Annual Meeting, the Committee on Arrangements has provided five half-hour intermission periods, which will fall during the first five of the six Scientific Sessions, for members to visit the sixty booths that have been rented to approved companies and agencies.

These intermissions were provided in order to give those attending the meeting the opportunity to become acquainted with the latest developments in medicine, appliances, medical literature, equipment and other services that a physician must have knowledge of.

It was also pointed out that through rentals paid for the spaces, which are priced from \$125.00 to \$200.00 per unit, funds are derived that make it possible to have such a splendid Scientific Program and other features without cost to the membership. Were it not for these rentals it would be necessary to charge a registration fee of \$15.00 in order to have a meeting of comparable value.

The Committee on Arrangements joins with the Committee on Technical Exhibits in urging the members to visit each of the booths during the Annual Meeting.

Scientific Movies to be Shown in Basement Lounge

The Subcommittee on Scientific Movies of the Committee on Arrangements will present carefully selected scientific movies continuously in the Basement Lounge during the Annual Meeting, October 7, 8 and 9, Charles L. Edelen, M. D., Louisville, Chairman of the Subcommittee, said.

Members may find it possible to see a given movie at an appointed time, if the request is made to attendants in the Basement Lounge far enough in advance. Schedules of the showings of these movies may be had at the time of the meeting.

Other members of the Subcommittee are: R. Arnold Griswold, M. D., Louisville; J. A. Bishop, M. D., Jeffersontown; Robert Lich, M. D., Louisville; and Lillian South, M. D., Louisville, who is taking care of arrangements for the showing of the movies.

:--: Guest Speakers :--:

ALFRED STEINER, M. D.

New York City



Alfred Steiner, M. D., New York City, was born in Richmond, Virginia, in 1910, and received his Doctor of Medicine degree from the Medical College of Virginia in 1933. The next three years were spent at the Metropolitan Hos-

pital in New York, and from 1936 to 1939 he was a resident in Research Medicine, Columbia Division of the Goldwater Memorial Hospital.

He received his Doctor of Medical Science (Internal Medicine) at the College of Physicians and Surgeons, Columbia University, in 1938. At this institution he became Instructor in Medicine in 1940 where he has served since, now holding the chair of Assistant Clinical Professor of Medicine. He has written some 25 articles for medical journals on heart disease.

He is a member of the American Heart Association, American Federation for Clinical Research and the American Society for the Study of Arteriosclerosis.

PAUL D. CRIMM, M. D.

Evansville, Indiana

Paul D. Crimm received his academic work at Ohio Wesleyan and his medical training was taken at Western Reserve University. He received his hospital training at University Hospital in Cleveland. He is a veteran of World War I. For the past 22 years, he has been Director and Chest Surgeon of the Boehne Tuberculosis Hospital in Evansville, Indiana.



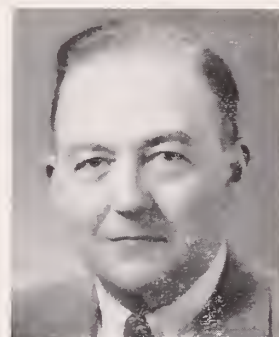
Dr. Crimm has been very active in organized medicine and in the field of chest diseases. He is past president of his coun-

ty medical society and was the 102nd President of the Indiana State Medical Association. He is a member of the American College of Chest Physicians, American Trudeau Society, American Association for Thoracic Surgery and American College of Physicians.

RICHARD B. CAPPS, M. D.

Chicago, Illinois

Richard B. Capps, M. D., was born in 1906. After graduating at Princeton University, he received his M. D. Degree at Harvard Medical School in 1931. Two years of his hospital training was spent at Massachusetts General and two more at Boston City. In 1936, he became Instructor in Medicine at Northwestern Medical School, and in 1938 Associate in Medicine at the same school. Since 1946, he has served as Assistant Professor in Medicine at Northwestern University Medical School.



After serving four years in the Army Medical Corps, Dr. Capps was separated with the rank of Lt. Colonel. While in the service, Dr. Capps was given special assignments in the field of hepatitis. He is a Fellow in the American College of Physicians, a member of the American Society of Clinical Investigation, American Heart Society and the American Clinical and Climatological Society. He is certified by the American Board of Internal Medicine.

**JOHN B. ELSEVER, M. D., AND
MARION LOUISE CHOISSEY MILLS,
M. D.**

Washington, D. C.

John B. Elsever, M. D., finished his academic training at Syracuse University in 1930 and graduated from the Harvard Medical School in 1934. Following internship and medical residency at Brigham Hospital, Boston (1934-37), he served as Instructor in Internal Medicine at Syracuse University Medical School until 1942. Here he organized and directed the Blood Transfusion Service and did re-

search in blood and plasma preparation.

Dr. Alsever, who is certified by the American Board of Internal Medicine and who belongs to the American College of Physicians, holds the rank of Colonel in the United States Public Health Service. After holding numerous positions in the Government's blood program, he became Chief of the Blood Program of the Health and Special Weapons Defense Division, of the Federal Civil Defense Administration in 1951, where he is now serving. Dr. Alsever has published a text-book "Blood Transfusion" (W. B. Saunders Co., 1949).

Collaborating with Dr. Alsever in the presentation of his paper at the Annual Meeting is Marion Louise Choisser Mills, M. D., who was born in Haiti in 1921. She graduated from George Washington University with an A. B. Degree in 1942 and from the University's Medical School in 1947. Since completing her internship at Gallinger Hospital in Washington, she has been working in the blood program and is now Assistant Chief to Dr. Alsever. She is a diplomate of the National Board.

NORVIN C. KIEFER, M. D.

Washington, D. C.



Norvin Charles Kiefer, M. D., a native of Lorain, Ohio, was born in 1905, took his pre-medical work at Western Reserve and graduated from the University of Michigan School of Medicine in 1930. Following his internship at Miami Valley Hospital, Dayton, Ohio, he entered private practice at Geneva, where he practiced internal medicine until 1945, when he was commissioned in the Regular Corps of the United States Public Health Service. In 1946 he received his Master of Public Health at Johns Hopkins University.

In 1948 he was placed in charge of a new program of Health Emergency Planning; in 1949, he became Director of the Medical Services Division of the National Security Resources Board; and in 1950 Director of the Health and Special Weapons Defense Division of the Federal Civil Defense Administration. He is a Fellow in the American College of Allergists,

American Society of Tropical Medicine, American Trudeau Society and the Association of Military Surgeons.

FRANK E. HAGMAN, M. D.

Denver, Colorado

Frank E. Hagman was born in 1901. He received his degree from the University of Colorado School of Medicine in 1930 and finished his internship at the Medical Center, Jersey City, New Jersey, in 1931. The next four years were spent at the center where he took his surgical residency.



Colonel Hagman, who is in the regular army, has just finished an assignment with the Far East Command in Korea as Surgical Consultant, Medical Section, at General Headquarters. His present assignment is Assistant Director of Surgery, Fitzsimmons Army Hospital, Denver, Colorado.

EUGENE M. BRICKER, M. D.

St. Louis, Missouri

Eugene M. Bricker was born in Carbondale, Illinois, in 1908 and graduated from the Washington University Medical School in 1934. The St. Louis surgeon took his training at Barnes Hospital and in 1939 became Chief Surgeon at the Ellis Fischel State Cancer Hospital where he served until 1942.



After entering the Army Medical Corps he was appointed Senior Consultant in Plastic Surgery in the European Theatre of Operations for the period of 1943-45. Returning to St. Louis, he became Associate Professor of Clinical Surgery at his alma mater in 1946, which position he holds at this time. He is a member of the American Board of Surgery, American Board of Plastic Surgery and American College of Physicians. He is the current president of the Society of University Surgeons.

CYRIL M. MacBRYDE, M. D.

St. Louis, Missouri

Cyril M. MacBryde, M. D., a native of St. Louis, was born in 1906. He graduated from Washington University in 1926 and received his M. D. Degree from Harvard in 1930, and took his internship assistant residency at Barnes Hospital. He was a fellow in Metabolic and Endocrine Research at University of Vienna, Austria, until January of 1933 and then Fellow, University of Berlin, until June of 1933. He returned to St. Louis and became associated with the Washington University School of Medicine and served in various teaching capacities until 1946.



The St. Louis internist is a member of the American Society for Clinical Investigation, American Diabetes Association, and a Fellow in the American College of Physicians. He is a diplomate in the American Board of Internal Medicine and is on the editorial boards of Modern Medicine and the Journal of Clinical Nutrition. He is the author of the text book "Signs and Symptoms" (Lippincott—second edition, 1952, just published).

MARSHALL BRUCER, M. D.

Oak Ridge, Tennessee



Marshall Brucer was born in Chicago, Illinois, in 1913, and after receiving his academic education in the Chicago school system and the University of Chicago, he was awarded his M. D. Degree from the University of Chicago School of

Medicine in 1941. After completing his training at the University of Chicago, Northwestern University and the Boston City Hospital, he entered the Airborne Command, U. S. Army. He was discharged in 1946 with the rank of Lt. Colonel.

After serving teaching appointments at

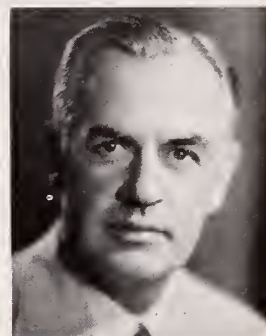
the University of Texas Medical Branch, he became Chairman of the Medical Division of the Oak Ridge Institute of Nuclear Studies at Oak Ridge, Tennessee, in 1948, which position he still occupies. He is a member of the American Statistical Association, the Biometric Society, American Association for the Advancement of Science and the Society for Experimental Biology and Medicine.

ARTHUR R. COLWELL, M. D.

Evanston, Illinois

Arthur R. Colwell was born in 1897. He graduated from Rush Medical College, Chicago, in 1921.

Dr. Colwell is the Irvings S. Cutter Professor and Chairman of the Department of Medicine, Northwestern University School of Medicine, Chicago. He is Chairman of the Division of Medicine, Passavant Memorial Hospital, Chicago, and President of the American Diabetes Association. He is a widely known medical writer and is author of numerous medical publications, including two books on diabetes mellitus.



GEORGE BOND, M. D.

Bat Cave, North Carolina



George Bond, born in 1915, received his B. A. and M. A. degrees at the University of Florida. He was awarded the degree of Doctor of Medicine from the University of McGill, Montreal, Canada, in 1946. At present is Medical

Director of the Valley Clinic and twelve bed hospital at Bat Cave, North Carolina.

He is Chairman of the Committee on Rural Health and Education of the Medical Society of the State of North Carolina. Nationally recognized as an authority on Rural Health, Dr. Bond has traveled some 20,000 miles addressing various groups. He was the principal

character in a movie that was made for the American Medical Association and which received wide distribution.

JUDGE L. R. CURTIS

Louisville



Lee Roy Curtis was born in Woodford County, Kentucky, in 1880. After attending school in Versailles, he finished Law School at the University of Louisville in 1903. He also took special work at the University of Michigan School of Law. For many years, he was a member of the faculty of the University of Louisville, teaching medical jurisprudence. For more than twenty-five years, he represented the Kentucky State Medical Association, the Kentucky State Dental Association and leading underwriters of professional liability coverage.

In the fall of 1950, he was appointed Circuit Judge of Jefferson County by the Governor, and in 1951 was elected to a six-year term. Judge Curtis has enjoyed a wide practice. He has specialized in corporation law and has numbered many of the large casualty insurance companies among his clients.

Nominating Committee Plans Oct. 6 Session at Auditorium

Officers to be elected at the Annual Meeting by the House of Delegates for the 1952-53 year are:

President-Elect
Vice-President—Central
Vice-President—Eastern
Vice-President—Western
Orator in Medicine
Orator in Surgery
Councilor from the Tenth District

The Nominating Committee will consider nominations for these offices at a meeting immediately after the first session of the House of Delegates in the Columbia Auditorium, Monday evening, October 6, at a place to be announced, Hugh L. Houston, M. D., Murray, Speaker, has announced.

The Committee, composed of Woodford B. Troutman, M. D., Louisville, Chairman; Howell J. Davis, M. D., Owensboro; and

Charles B. Stacy, M. D., Pineville, will welcome suggestions from the membership for each of these offices, Dr. Houston said.

The Committee will make its report at the second Scientific Session on Tuesday afternoon. Elections will be held Wednesday evening, October 8, at the second session of the House of Delegates. In addition to nominations presented by the Committee, Dr. Houston pointed out that nominations for a given office may also be made from the floor.

Annual KSMA Golf Tournament to be Held at Big Springs

The Big Springs Country Club, site of the 1952 Tournament of the Professional Golf Association, has made available its facilities for the Annual K.S.M.A. Golf Tournament, Sam A. Overstreet, M. D., Louisville, Chairman of the Golf Committee, has announced.

Visiting physicians may play as guests of individual club members or by paying greens fee at clubhouse at any time Monday, Tuesday, Wednesday or Thursday, October 6, 7, 8 and 9. Prizes awarded tournament winners will be announced at the Annual Dinner, Thursday evening, October 9.

Other members of the Golf Committee are: William C. Wolfe, M. D., Louisville; Leo W. Zimmerman, M. D., Louisville; W. Vinson Pierce, M. D., Covington; Paul Hall, M. D., Paintsville.

Selection of Delegates Outlined

The attention of County Societies who have not sent in the name of their delegate is called to Chapter IV, Section 2, of the By-Laws:

"In the event there is no duly authorized delegate in attendance at the regular meeting of the House of Delegates the President shall consult any duly elected officer of the component society who is in attendance and with the approval of the Credentials Committee may appoint any active member of the component society in attendance at the meeting as the delegate. In the event there is no duly elected officer of the component society in attendance, the President may make the said appointment with the approval of the Credentials Committee. All appointments made shall also be with the approval of the House of Delegates."

OFFICIAL CALL

ANNUAL MEETING

KENTUCKY STATE MEDICAL ASSOCIATION

To the officers and members of the component county societies of the Kentucky State Medical Association.

Meeting Place

The Annual Meeting of the Kentucky State Medical Association will convene at the Columbia Auditorium, Louisville, Tuesday, Wednesday, and Thursday, October 7-9, 1952. The General Session will be called to order at 9:00 A. M., and the First Scientific Session will begin at 9:30 A. M., Tuesday, October 7.

The House of Delegates

The First Regular Session of The House of Delegates will convene at 7:30 P. M., Monday, October 6; the Second Regular Session will begin at 7:30 P. M., Wednesday, October 8. Both sessions will be held in the Columbia Auditorium.

Registration

The Registration Department will be open in the Columbia Auditorium from 6:00 P. M. to 8:00 P. M. on Monday, October 6; from 8:00 A. M. to 5:00 P. M. on Tuesday, October 7; from 8:00 A. M. to 5:00 P. M. on Wednesday, October 8; and from 8:00 A. M. to 5:00 P. M. on Thursday, October 9.

WOMAN'S AUXILIARY

To The

KENTUCKY STATE MEDICAL ASSOCIATION

Tuesday, October 7, 1952, Brown Hotel

Pre-Convention Board Breakfast, 8:30 A. M., South Room; Formal Opening of the Thirtieth Annual Meeting, 1:00 P. M., South Room.

Wednesday, October 8, Brown Hotel

Morning Session, 9:00 A. M., South Room; Afternoon Session, beginning with a Subscription Luncheon and Style Show, 1:00 P. M., Crystal Ballroom.

Thursday, October 9, Brown Hotel

Subscription Breakfast and Post-Convention Board of Directors Meeting, 8:30 A. M., South Room.

Registration

The Registration Department of the Woman's Auxiliary will be open in the North Bay of the Lobby, Brown Hotel, on Monday, October 6, from 12:00 Noon to 5:00 P. M.; Tuesday, October 7, from 9:00 A. M. to 5:00 P. M.; Wednesday, October 8, 9:00 A. M. to 11 A. M.

Special Phone, WA6903, Arranged For Annual Meeting

If you wish to be reached in the minimum length of time while attending the Annual Meeting at the Columbia Auditorium, October 7, 8 and 9, have those who want you to call Louisville-WAbash 6903.

Through special arrangements with the Telephone Company, the Association will have a number in the temporary Headquarters Office at the Auditorium, for incoming calls only. Four pay stations are conveniently located for outgoing calls.

Chest Physicians to Meet

Paul D. Crimm, M. D., Evansville, Indiana, will be the luncheon speaker at the annual meeting of the Kentucky Chapter of the American College of Chest Physicians during the Annual Meeting of the Association at the Brown Hotel, Tuesday, October 7, Hugh L. Houston, M. D., Murray, has announced.

Dr. Crimm, long active in chest surgery work, is director and past president of the Indiana State Tuberculosis Association. At present he is Director and Chest Surgeon at the Boehne Tuberculosis Hospital in Evansville.

E. Rudolph Gernert, M. D., Louisville, is Vice-President of the Kentucky Chapter, and Lawrence A. Taugher, M. D., Louisville, is Secretary. T. Ashby Woodson, M. D., Louisville, has recently been re-elected by the national organization as Governor for Kentucky.

If you are one of those who has not made remittance for the Centennial Volume, which you ordered at the last Annual Meeting and which has been sent to you, the Centennial Committee urges you to settle for your book at the especially provided table in the Exhibit Hall during the 1952 session.

Program

THE DANIEL DRAKE MEMORIAL MEETING

of the

KENTUCKY STATE MEDICAL ASSOCIATION

OCTOBER 6, 7, 8, 9, 1952

LOUISVILLE

MONDAY, OCTOBER 6

- 3:00 P.M. Council Meeting Louis XVI Room, Brown Hotel
 5:00 P.M. Council Dinner Louis XVI Room, Brown Hotel
 6:00 P.M. Registration of House of Delegates..... Columbia Auditorium
 7:00 P.M. First Meeting of House of Delegates..... Columbia Auditorium

TUESDAY, OCTOBER 7

- 8:00 A.M. Registration Columbia Auditorium
 9:00 A.M. Opening of the General Session..... Columbia Auditorium
 9:15 A.M. First Scientific Session Columbia Auditorium
 2:00 P.M. Second Scientific Session..... Columbia Auditorium
 2:00 P.M. Reference Committee Meetings..... Columbia Auditorium
 8:15 P.M. General Public Meeting..... Columbia Auditorium

WEDNESDAY, OCTOBER 8

- 9:00 A.M. Third Scientific Session..... Columbia Auditorium
 12:00 A.M. President's Luncheon for Distinguished Guests Roof Garden, Brown Hotel
 2:00 P.M. Fourth Scientific Session Columbia Auditorium
 5:00 P.M. Council Dinner Louis XVI Room, Brown Hotel
 6:00 P.M. Registration, House of Delegates..... Columbia Auditorium
 7:00 P.M. Second Meeting, House of Delegates..... Columbia Auditorium

THURSDAY, OCTOBER 9

- 9:00 A.M. Fifth Scientific Session..... Columbia Auditorium
 12:15 P.M. Council Luncheon Parlors A, B & C, Brown Hotel
 2:00 P.M. Sixth Scientific Session..... Columbia Auditorium
 7:30 P.M. The Annual Banquet Crystal Ballroom, Brown Hotel

A 30-Minute intermission has been scheduled during each morning and afternoon Scientific Session for visiting the Scientific and Technical Exhibits.

SCIENTIFIC PROGRAM

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THE DANIEL DRAKE MEMORIAL MEETING

COLUMBIA AUDITORIUM

* * * *

THE KENTUCKY STATE MEDICAL ASSOCIATION

Louisville, Kentucky

October 7, 8, 9, 1952

Tuesday, October 7

COLUMBIA AUDITORIUM

REGISTRATION

8:00 - 9:00 A. M.

OPENING OF GENERAL SESSION

9:00 A. M.

Call to Order by the President

Clark Bailey, M. D., Harlan

Invocation

Reverend Charles G. Maloney, Holy Name Church, Louisville

Welcoming Remarks

Richard R. Slucher, M. D., President, Jefferson County Medical Society, Buechel

Announcements

R. Haynes Barr, M. D., President-Elect, Kentucky State Medical Association, Owensboro

Tuesday, October 7

FIRST SCIENTIFIC SESSION

9:30 A. M.

Clark Bailey, M. D., Harlan, Moderator

9:30 Diet and Arteriosclerosis, With Special Reference to Coronary Arteriosclerosis

Alfred Steiner, M. D., New York, New York

10:00 Mitral Stenosis—Its Surgical Correction

W. Burford Davis, M. D., Louisville

10:30 Visit the Exhibits

11:00 Obstetrical Anesthesia In General Practice

Warren F. Sargent, M. D., St. Joseph Hospital, Lexington

11:30 ORATION IN MEDICINE

The General Practitioner Sees the Hypertensive Patient

Joseph M. Bush, M. D., Mt. Sterling

* * *

12:15 Luncheon—Brown Hotel

Sponsored by Kentucky Chapter, American College of Chest Physicians

Review of a Seventy Thousand Microfilm Program

Paul Crimm, M. D., Evansville, Indiana

Tuesday, October 7

SECOND SCIENTIFIC SESSION

2:00 P. M.

R. Haynes Barr, M. D., Owensboro

Moderator

2:00 The Diagnosis of Lung Lesions

Paul Crimm, M. D., Evansville, Indiana

2:30 Management of Carcinoma of the Cervix Uteri

Jesshill Love, M. D., Irvin H. Sonne, Jr., M. D., Robert Greco, M. D., Louisville

3:00 Visit the Exhibits

3:30 Infectious Hepatitis

Richard B. Capps, M. D., Chicago, Illinois

4:00 Functional Fixations of Fractures of Upper Extremities

William K. Massie, M. D., Lexington

4:30 Adjournment

GENERAL PUBLIC MEETING

COLUMBIA AUDITORIUM

Tuesday, October 7

8:15 P. M.

R. Haynes Barr, M. D., President-Elect, Owensboro, Presiding

Invocation

Reverend Thomas M. Giltner, Douglass
Boulevard Christian Church Louisville

Welcome

Clark Bailey, M. D., President, Harlan

Recognitions**Presentation of the J. Watts Stovall Award**

Clark Bailey, M. D., Harlan

Presentation of the E. M. Howard Medal

Clark Bailey, M. D., Harlan

Presentation of the Kentucky Medical Association Distinguished Service Award

Clark Bailey, M. D., Harlan

Introduction of Guest Speaker

R. Haynes Earr, M. D., Owensboro

Medical Aspects of Atomic Defense

Colonel Gerald M. McDonnell, Washington,
D. C., Chief of the Armed Forces Special
Weapons Project

Benediction

Reverend Thomas M. Giltner, Douglass
Boulevard Christian Church, Louisville

Wednesday, October 8

THIRD SCIENTIFIC SESSION

9:00 A. M.

Keith Smith, M. D., Corbin,
Moderator

9:00 The Duties and Responsibilities of the Doctor and the State Medical Association in Civil Defense

G. Y. Graves, M. D., Bowling Green

9:15 Civil Defense Health Services and Special Weapons Defense

Norvin Keifer, M. D., Director, Division of Health and Special Weapons Defense, Washington, D. C.

9:45 Management of Casualties in Korea

Col. Frank E. Hagman, Denver, Colorado

10:10 The Civil Defense Blood Program

John L. Alsever, Washington, D. C.

10:30 Visit the Exhibits**11:00 ORATION IN SURGERY
Geriatric Surgery**

Gaiñhel L. Simpson, M. D., Greenville

11:30 Adjournment**PRESIDENT'S LUNCHEON****ROOF GARDEN — BROWN HOTEL**

Wednesday, October 8

12:00 Noon

Clark Bailey, M. D., President, Harlan
Presiding

Invocation

Dr. Joseph M. Rauch, Rabbi-Temple Israel,
Louisville

Introduction of Past Presidents of the Kentucky State Medical Association**Recognition of Visiting State Officers****Introduction of Distinguished Essayists****Bulwarks**

T. Russ Hill, Industrialist, Detroit, Michigan

Wednesday, October 8

FOURTH SCIENTIFIC SESSION

2:00 P. M.

Thomas Van Zandt Gudex, M. D., Louisville,
Moderator

2:00 Advances in the Surgical Management of Carcinoma of the Colon

Eugene Bricker, M. D., St. Louis,
Missouri

2:30 Rural General Practice, 1952

George Bond, M. D., Bat Cave, North
Carolina

3:00 Visit the Exhibits**3:30 The Doctor's Day in Court**

Judge L. R. Curtis, Louisville

4:00 Practical Aspects in the Treatment of Meningitis in Children

Robert N. McLeod, M. D., Somerset

4:30 Adjournment

Wednesday, October 8

COLUMBIA AUDITORIUM

7:30 P. M.

SECOND MEETING OF THE HOUSE OF DELEGATES

(All members are privileged to attend meeting of the House)

6:00-7:30 Registration of House of Delegates**7:30 Meeting of the House of Delegates**

Thursday, October 9

FIFTH SCIENTIFIC SESSION

9:00 A. M.

R. Ward Bushart, M. D., Fulton,
Moderator

9:00 Public Health Policies
Bruce Underwood, M. D., Louisville

9:30 Rationale of Good Control in the Treatment of Diabetes Mellitus

Arthur R. Colwell, M. D., Chicago,
Illinois

10:00 Otagia
William L. Woolfolk, M. D., Owensboro

10:30 Visit the Exhibits

11:00 ACTH and Cortisone
Cyril M. MacBryde, M. D., St. Louis,
Missouri

11:30 Modern Treatment of Burns
Roy H. Moore, Jr., M. D., Louisville

12:00 Adjournment

All exhibits will be closed before the Sixth
Scientific Session

Thursday, October 9

SIXTH SCIENTIFIC SESSION

2:00 P. M.

Clark Bailey, M. D., Harlan,
Moderator

2:00 Isotopes and Radiation
Marshall Brucer, M. D., Oak Ridge,
Tennessee

2:30 Endocrinology Phases of Gynecology
W. O. Johnson, M. D., Louisville

3:00 When a Psychiatric Case Walks Into Your Office

Billy K. Keller, M. D., Louisville

3:30 Surgery of the Hand
Richard J. Rust, M. D., Newport

4:00 Adjournment

ANNUAL BANQUET

CRYSTAL BALLROOM — BROWN HOTEL

7:30 P. M.

Clyde C. Sparks, M. D., Ashland, Toastmaster
(Dress Optional)

Invocation

Reverend Lucius M. Polhill, Deer Park Baptist Church, Louisville

Dinner

Welcome

Charles Farnsley, Mayor, Louisville

Recognitions

Presentation of Golf Trophies

Sam Overstreet, M. D., Louisville

Remarks of President-Elect and Charge to New Members

R. Haynes Barr, M. D., Owensboro

Address

Which Direction?

Clark Bailey, M. D., Harlan

Inaugural Ceremony

Benediction

Reverend Lucius M. Pohill, Deer Park Baptist Church, Louisville

THIRTIETH ANNUAL MEETING

of the

WOMAN'S AUXILIARY

to the

Kentucky State Medical Association

SOUTH ROOM, BROWN HOTEL

Louisville, Kentucky

October 7-8-9, 1952

REGISTRATION HOURS:

North Bay of Lobby, Brown Hotel

Monday—Noon to 5:00 P. M.

Tuesday—9:00 A. M. to 5:00 P. M.

Wednesday—9:00 A. M. to 11 A. M.

Chairman of

Registration.....Mrs. Sam Overstreet
Louisville

Tuesday, October 7

8:30 A. M.

South Room, Brown Hotel

Pre-Convention Board Breakfast (subscription)
(The Board consists of all general state officers, councilwomen, state committee chairmen, county auxiliary presidents, and three immediate past presidents.)

Tuesday, October 7

1:00 P. M.

South Room

Formal opening of the Thirtieth Annual Meeting of the Woman's Auxiliary to the Kentucky State Medical Association.

Presiding.....Mrs. John Harter
Louisville, President

Invocation.....Mrs. Charles B. Johnson
Russell, Councilor
Thirteenth District

Pledge of Allegiance
to the Flag.....Mrs. Clark Bailey
Harlan, Immediate
Past President

Pledge of Loyalty.....Mrs. Clark Bailey
I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

Address of Welcome....Mrs. J. Andrew Bowen
Louisville, President,
Jefferson County Auxiliary

Response.....Mrs. R. W. Bushart
Fulton, Vice-President

In Memoriam.....Mrs. Clyde Sparks
Ashland, Historian

Presentation of Convention
Chairman.....Mrs. A. R. Kasey, Jr.
Louisville

Presentation of Distinguished Guests
Roll Call.....Mrs. C. Melvin Bernhard
Louisville, Secretary

Minutes of the Twenty-Ninth Annual Meeting.....Mrs. C. Melvin Bernhard

Report of the 1952 National Convention.....Mrs. John B. Floyd, Jr.
Lexington

Report of Councilor of Woman's Auxiliary to Southern Medical Association.....Mrs. James A. Ryan
Covington

REPORTS OF OFFICERS:

Treasurer.....Mrs. A. B. Colley
Calhoun

President-Elect..Mrs. David Woolfolk Barrow
Lexington

President.....Mrs. John Harter

Old Business

New Business

Report of Nominating
Committee.....Mrs. Clark Bailey, Chairman

Election of Nominating Committee, 1952-1953

Presentation of 1952-1953
Budget.....Mrs. Hugh L. Houston
Murray, Finance Chairman

Report of Registration....Mrs. Sam Overstreet
Recess

Reports of County Auxiliary Presidents

Reports of State Chairmen

Tuesday, October 7

8:15 P. M.

Annual Public Meeting, Kentucky State Medical Association, Columbia Auditorium

Speaker.....Colonel Gerald M. McDonnell
Washington, D. C.

Wednesday, October 8

9:00 A. M.

South Room

Reading of Minutes..Mrs. C. Melvin Bernhard

Roll Call.....Mrs. C. Melvin Bernhard

Announcements.....Mrs. A. R. Kasey, Jr.
Convention Chairman

Panel Public Service
Clark Bailey, M. D., Harlan,
President, Kentucky State Medical Association

R. Haynes Barr, M. D., Owensboro,
President-Elect, Kentucky State Medical Association

Mrs. Clark Bailey,
Public Relations Chairman and Past-President

Mrs. G. B. Froage, Paducah,
President, McCracken County Auxiliary,
A Member-at-Large

Report of Revisions
Committee.....Mrs. E. Lee Heflin
Chairman, Louisville

Old Business

New Business

Election of Officers

Presentation of Distinguished Guests
Mrs. Ralph Eusden, President, Woman's Auxiliary to the American Medical Association, Long Beach, California
Mrs. V. Eugene Holcombe, President, Woman's Auxiliary to the Southern Medical Association, Charleston, West Virginia
Installation of Officers.....Mrs. Ralph Eusden
Inaugural
Address.....Mrs. David Woolfolk Barrow
Announcement of Committee
Chairmen.....Mrs. David Woolfolk Barrow
Final Report of
Registration.....Mrs. Sam Overstreet
Adjournment

Wednesday, October 8

Crystal Ballroom
1:00 P. M.

Subscription Luncheon and Style Show
To Honor: Mrs. Ralph Eusden and Mrs. Eugene Holcombe
Invocation.....Mrs. J. B. Helm
Smiths Grove, President,
Warren County Auxiliary
Presentation of Officers
Presentation of Distinguished Guests
Message.....Mrs. Ralph Eusden
President, Woman's Auxiliary
to American Medical Association

Thursday, October 9

South Room 8:30 A. M.
Subscription Breakfast

Post-Convention Board of Directors
Meeting.....Mrs. David Woolfolk Barrow
President

Thursday, October 9

7:00 P. M.
Crystal Ballroom

Annual Subscription Dinner of the Kentucky State Medical Association

STATE CONVENTION COMMITTEES

General Chairman.....Mrs. A. R. Kasey, Jr.
Louisville
Registration.....Mrs. Sam Overstreet
Louisville

Entertainment.....Mrs. Earl W. Roles
Louisville
Hospitality.....Mrs. John Gordinier
Louisville
Hospitality Room.....Mrs. John Gordinier
For Members-at-Large
Mrs. T. Ashby Woodson, Louisville
Publicity.....Mrs. Malcolm Barnes
Louisville

WOMAN'S AUXILIARY TO THE KENTUCKY
STATE MEDICAL ASSOCIATION

1951 - 1952

State Officers

President: Mrs. John Harter, Louisville
President-Elect: Mrs. Woolfolk Barrow, Lexington
Vice-President: Mrs. Karl Winter, Louisville
Vice-President: Mrs. William Cartmell, Maysville
Vice-President: Mrs. Keith Smith, Corbin
Vice-President: Mrs. R. W. Bushart, Fulton
Recording Secretary: Mrs. C. Melvin Bernhard, Louisville
Corresponding Secretary: Mrs. Gordon Buttorff, Louisville
Treasurer: Mrs. A. B. Colley, Calhoun
Parliamentarian: Mrs. Philip E. Blackerby, Louisville

Directors

Mrs. R. Haynes Barr, Owensboro
Mrs. Elbert W. Jackson, Paducah
Mrs. Clark Bailey, Harlan

District Councilors

1st—Mrs. Vernon Pace, Paducah
2nd—Mrs. John S. Oldham, Owensboro
3rd—Mrs. R. E. Davis, Central City
4th—Mrs. J. L. Dishman, Greensburg
5th—Mrs. T. Ashby Woodson, Louisville
6th—Mrs. William McCormack, Bowling Green
7th—Mrs. Carl Boylen, Carrollton
8th—Mrs. Luther Bach, Newport
9th—Mrs. John Cummings, Flemingsburg
10th—Mrs. John Prewitt, Lexington
11th—Mrs. William Cloyd, Richmond
12th—Mrs. George Griffith, Mt. Vernon
13th—Mrs. Charles B. Johnson, Russell
14th—Mrs. Thurman Perry, Jenkins
15th—Mrs. Samuel Flowers, Middlesboro

Advisory Committee

E. Lee Heflin, M. D., Louisville
Hugh L. Houston, M. D., Murray
J. B. Lukins, M. D., Louisville

Committee Chairmen

Program: Mrs. Dargan Smith, Owensboro
 Public Relations: Mrs. Clark Bailey, Harlan
 Today's Health: Mrs. J. M. Bray, Greenville
 Revisions: Mrs. E. Lee Heflin, Louisville
 Health Education: Mrs. Shelby Carr, Richmond
 Tuberculosis: Mrs. John B. Floyd, Richmond
 Nurse Recruitment: Mrs. D. G. Miller, Jr., Morgantown
 Finance: Mrs. Hugh Houston, Murray
 Historian: Mrs. Clyde Sparks, Ashland
 Benevolence: Mrs. E. W. Garred, Catlettsburg
 Legislation: Mrs. E. L. Henderson, Louisville
 Doctor's Shop: Mrs. Carroll Price, Harrodsburg
 McDowell House: Mrs. Walker Owens, Mt. Vernon
 Bulletin: Mrs. J. M. Bush, Mt. Sterling
 Cancer: Mrs. John B. Floyd, Jr., Lexington
 Heart: Mrs. Edward Wilson, Jr., Pineville
 Civil Defense: Mrs. Irving Gail, Lexington
 Nominations: Mrs. Clark Bailey, Harlan

Reference Committee Appointees Announced by Speaker

Appointments to the five Reference Committees and the Credentials Committee of the House of Delegates at the 1952 Annual Meeting at the Columbia Auditorium, October 6, 7, 8, and 9, have been made by Hugh L. Houston, M. D., Murray, Speaker of the House.

The House will hold its first meeting at the Auditorium at 7:30 o'clock Monday evening, October 6. During this meeting the 50 odd annual reports to the House will be submitted by the various officers, committees and agencies of the Association. These reports will be referred to one of the five Reference Committees.

The Reference Committees will meet at 2 p. m. Tuesday afternoon to consider these reports. Any member of the House of Delegates or any member of the Association, Dr. Houston says, "Is more than welcomed to appear before any of the Reference Committees and express his views on any of the issues the House may be asked to consider. If any member does not know when or where a given Reference Committee meets, he is urged to ask his Councilor, any of the Officers of the Association, or at the Information Window of the Registration cage."

After the Reference Committee hearings, the Committees will then write their reports and recommendations, which will be submitted to the House of Delegates at

its final session, Wednesday evening, October 8, at 7:30 p. m. At this time these matters will be discussed and the House will take final action.

Appointees of the committees are listed below:

REFERENCE COMMITTEE No. 1

(Order and Rules of Business and Reports of Officers and Councilors)

E. M. Howard, M. D., Harlan, Chairman
 Laman A. Gray, M. D., Louisville, Vice-Chairman

W. V. Lyons, M. D., Ashland
 Theodore L. Adams, M. D., Lexington
 Robert L. Reeves, M. D., Paducah

REFERENCE COMMITTEE No 2

(Standing Committee)

W. Vinson Pierce, M. D., Covington, Chairman

Richard G. Elliott, M. D., Lexington, Vice-Chairman

John W. Meredith, M. D., Scottsville
 Robert A. Orr, M. D., Mayfield
 Price Sewell, Jr., M. D., Jackson

REFERENCE COMMITTEE No. 3

(Reports of Special Committees)

Richard J. Rust, M. D., Newport, Chairman

Gradie R. Rowntree, M. D., Louisville, Vice-Chairman

Keith P. Smith, M. D., Corbin
 B. Ralph Wilson, M. D., Sharpsburg
 John P. Glenn, M. D., Russellville

REFERENCE COMMITTEE No. 4

(Reports of Advisory Committees)

George W. Pedigo, M. D., Louisville, Chairman

Frank L. Duncan, M. D., Monticello, Vice-Chairman

Leon Higdon, M. D., Paducah
 S. B. May, M. D., Eminence
 T. O. Meredith, M. D., Harrodsburg

REFERENCE COMMITTEE No. 5

(Resolutions Committee)

Charles B. Stacy, M. D., Pineville, Chairman

Howell J. Davis, M. D., Owensboro, Vice-Chairman

Coleman J. McDevitt, M. D., Murray
 John D. Handley, M. D., Hodgenville
 John W. Scott, M. D., Lexington

REFERENCE COMMITTEE No. 6

(Credentials Committee)

D. G. Miller, M. D., Morgantown, Chairman

Carlisle Morse, M. D., Louisville, Vice-Chairman

H. H. Rutledge, M. D., Richmond

House of Delegates to Meet Oct. 6 At Columbia Auditorium

The House of Delegates of the Kentucky State Medical Association will hold its first session of the Annual Meeting in the Columbia Auditorium Monday evening, October 6, at 7:30 P. M., with the registration desk opening at 6:00 P. M.

At the first meeting, resolutions, new business and the reports by Officers, Councilors and Committee Chairmen will be submitted. These matters will be assigned by Speaker of the House, Hugh L. Houston, M. D., Murray, to the various Reference Committees. The Committees will consider this material Tuesday afternoon, and make their reports back to the House Wednesday evening, October 8.

The House will hold its second meeting on Wednesday evening, October 8, in the Columbia Auditorium. Registration of the members will start at 6:00 P. M., and the meeting will open at 7:00. All members of the Association are welcomed at these meetings, except when the House is in executive session. At this meeting the reports of the Reference Committees are acted upon and new officers elected.

Delegates who will represent the component County Medical Societies of the Association and whose names had been certified to the Headquarters Office as the deadline for this issue was reached are listed below. Every County Medical Society is entitled to one delegate. One Delegate is apportioned for each twenty-five active members or major fraction thereof.

DELEGATES - 1952

Adair: James C. Salato, Columbia
Allen: John W. Meredith, Scottsville
Anderson: Geo. F. Gilbert, Lawrenceburg
Barren: William C. Wells, Glasgow
Bath: B. Ralph Wilson, Sharpsburg
Bell: C. B. Stacey, Pineville
Boone: Gladys L. Rouse, Florence
Bourbon: Erwin Asriel, Paris
Boyd: W. B. Lyon, Ashland, and Paul Holbrook, Ashland
Boyle: Chris S. Jackson, Danville
Bracken: J. M. Stevenson, Brooksville
Breathitt: Price Sewell, Jr., Jackson
Breckinridge: John A. Kincheloe, Hardinsburg
Bullitt: Bernard Popham, Lebanon Junction
Butler: D. G. Miller, Jr., Morgantown
Caldwell: Frank P. Giannini, Princeton
Calloway: Coleman McDevitt, Murray

Campbell-Kenton: W. V. Pierce, Covington; Richard Rust, Newport; O., W. Frickman, Newport; Maurice Walsh, Covington; Luther Bach, Florence

Carlisle: E. E. Smith, Bardwell

Carroll: H. V. Stewart, Carrollton

Carter: W. B. Bishop, Grayson

Casey: K. R. Adams, Liberty

Christian: Gabe A. Payne, Hopkinsville

Clark: Garland Clark, Winchester

Clay: W. E. Becknell, Manchester

Clinton: E. A. Barnes, Albany

Crittenden: James O. Nall, Marion

Cumberland: Joseph Schickel, Burkesville

Davies: Charles B. Wathen, Owensboro; Howell Davis, Owensboro

Edmonson: S. E. Farmer, Brownsville

Elliott: John F. Greene, Sandy Hook

Estill: S. G. Marcum, Irvine

Fayette: Theodore L. Adams, Lexington; N. L. Bosworth, Lexington; Allen Lee Cornish, Lexington; Richard G. Elliott, Lexington; Lawrence E. Hurt, Lexington; John Scott, Lexington

Fleming: W. A. Graham, Flemingsburg

Floyd: Melvin W. Wicker, Wayland

Franklin: Thomas P. Leonard, Frankfort

Fulton: D. L. Jones, Fulton

Gallatin: H. K. Dillard, Warsaw (now Louisville)

Garrard: Sam Harris, (now Baltimore, Md.) Lancaster

Grant: Lenore P. Chipman, Williamstown

Graves: Robert A. Orr, Mayfield

Grayson: C. L. Bland, Leitchfield

Green: Robert L. Shuffett, Greensburg

Greenup: C. B. Johnson, Russell

Hardin: C. F. Long, Elizabethtown

Harlan: P. J. Begley, Harlan; E. M. Howard, Harlan

Hart: Colby N. Cowherd (now St. Louis, Mo.) Munfordville

Henderson: John S. Newman, Henderson

Henry: S. B. May, Eminence

Hickman: V. A. Jackson, Clinton

Hopkins: Faull S. Trover, Madisonville

Jefferson: Byron Bizot, Louisville; Carlos A. Fish, Louisville; Layman A. Gray, Louisville; Robertson O. Joplin, Louisville; Shelby V. Love, Louisville; Paul Mapother, Louisville; Robert F. Monroe, Louisville; Carlisle Morse, Louisville; George W. Pedigo, Jr., Louisville; Harper E. Richey, Louisville, Henry G. Saam, Louisville; Rudy F. Vogt, Louisville; James E. Winter, Louisville; George F. Archer, Louisville; Everett H. Baker, Louisville; Marion F. Beard, Louisville; Glenn W. Bryant, Louisville; John S. Harter, Louisville; William K. Keller, Louisville; Lawrence T. Minish, Jr., Louisville; Roy Moore, Jr., Louisville; Gradie R. Rowntree, Louisville; David H. Thurman, Louisville; John M. Townsend, Louisville

Jessamine: J. S. Williams, Nicholasville
Johnson: John Turner, Paintsville
Knott: M. F. Kelly, Hindman
Knox: W. P. Clifton, Barbourville
Larue: J. D. Handley, Hodgenville
Lawrence: Forest F. Shely, Louisa
Letcher: Carl Pigman, Whitesburg
Lewis: Elwood Esham, Vanceburg
Lincoln: M. M. Phillips, Stanford
Logan: J. P. Glenn, Russellville
Lyon: M. H. Moseley, Eddyville
Madison: H. H. Rutledge, Richmond
Magoffin: Lloyd M. Hall, Salyersville
Marion: S. Cooper Clarkson, Lebanon
Marshall: Geo. C. McClain, Benton
Martin: John W. Ford, Inez
Mason: M. B. Denham, Maysville
McCracken: Leon Higdon, Paducah; Robert Reeves, Paducah
McCreary: R. M. Smith, Stearns
McLean: A. B. Colley, Calhoun
Meade: Alfred Glattauer, Brandenburg
Menifee: D. L. Graves, Frenchburg
Mercer: T. O. Meredith, Harrodsburg
Monroe: T. L. Carter, Tompkinsville
Montgomery: Joe M. Bush, Mt. Sterling
Morgan: Ralph L. Gullett, West Liberty
Muhlenberg: G. H. Rodman, Greenville
Nelson: W. Keith Crume, Bardstown
Nicholas: B. F. Reynolds, Carlisle
Ohio: Oscar Allen, Beaver Dam
Oldham: J. T. Walsh, LaGrange
Owen: Paul Harrison, Owenton
Owsley: W. H. Gibson, Booneville
Perry: C. D. Snyder, Hazard
Pike: A. G. Osborne, Pikeville
Pulaski: Barton L. Ramsey, Jr., Somerset
Rockcastle: Walker Owens, Mt. Vernon
Scott: H. G. Wells, Georgetown
Shelby: L. A. Wahle, Shelbyville
Simpson: L. F. Beasley, Franklin
Spencer: M. H. Skaggs, Taylorsville
Taylor: W. B. Atkinson, Campbellsville
Todd: Ralph D. Lynn, Elkton
Trigg: L. W. Blakey, Cadiz
Trimble: O. James Hurt, Bedford
Union: George Welker, Morganfield
Warren: W. R. McCormack, Bowling Green
Washington: Dixie E. Snider, Springfield
Wayne: Frank Duncan, Monticello
Whitley: Keith Smith, Corbin
Woodford: Olson Parrott, Versailles

Parking Space is available in large lots on either side of Fourth Street between the Auditorium and the Brown Hotel. City officials have warned us against attendants to the Annual Meeting parking in the alley behind the Auditorium.

Scientific Exhibits Well Located; Synopsis is Listed

The Scientific Exhibits at the Annual Meeting will be set up in the two rooms immediately to the right as you pass through the main entrance of the Columbia Auditorium, Everett L. Pirkey, M. D., Louisville, Chairman of the Committee on Scientific Exhibits, said.

The rooms are conveniently located, provide ample space for the scientific exhibits, yet they are away from the noise and confusion of convention traffic, the Chairman pointed out. Thirty minutes has been set aside during each scientific session for the members to view the exhibits.

Below is presented by the Committee a synopsis of each of the scientific exhibits that will appear at the Annual Meeting.

1. Management of Carcinoma of the Cervix

Jesshill Love, M. D., Irvin H. Sonne, Jr., M. D., and Robert Greco, M. D., St. Joseph Infirmary, Louisville, Ky.

Charts, placards, diagrams and sketches to illustrate the treatment of carcinoma of the cervix uteri. Several dummy radium applicators with X-ray films to illustrate radium therapy for cancer of the cervix. The materials will be arranged along the back wall and two sides or "fly-walls."

2. "Untreated" Bronchogenic Carcinoma: A Report of Thirty-Five Cases

George R. Tanner, M. D., and Harold Gordon, M. D., Veterans Administration Hospital, Louisville, Ky.

The exhibit is a self contained prefabricated panel with tabular data and descriptive conclusions and summaries based on the data. A portion of the exhibit consists of an illuminated cabinet with gross museum specimens. The exhibit as a whole is a clinical and pathologic correlation of manifestations due to bronchogenic carcinoma of various types. The purpose of the exhibit is to illustrate the "average" course of bronchogenic carcinoma unaffected by definitive therapy. Data of this type eventually will make unnecessary collection of statistics based on end results after a lapse of a specific number of years (example 5 or 10 years as now commonly used for neoplastic disease).

3. First Aid for Emergencies

Charles F. Wood, M. D., Kentucky Regional Committee on Trauma of the American College of Surgeons, Louisville, Ky.

Actual demonstrations will be given by vari-

ous local authorities on the use of first aid to relieve pain and reduce shock following trauma. Those physicians who are concerned with Civil Defense should be particularly interested in this material.

4. The Medical Technologist (ASCP)

Sister M. Simonette, The Registry of Medical Technologists of the American Society of Clinical Pathologists, Muncie, Indiana.

The exhibit is made up of posters regarding the requirements of certification; maps of distribution of registered medical technologists and of approved schools of medical technology; a photomontage of scenes in the office of the Registry, and possibly other charts.

5. America's Biggest Public Health Problem

Thomas P. Summers, Kentucky Tuberculosis Association, Louisville, Ky.

This is a small-size reproduction of the National Tuberculosis Association's large prize-winning public health exhibit. It states problems and indicates solutions in tuberculosis control.

6. Social Group Work—A New Service To The Emotionally Ill Patient in Private Hospital Care

J. Murray Kinsman, M. D., Arden E. Hardgrove, M. D., E. E. Landis, M. D., C. G. Gifford, M. D., and S. Spafford Ackerly, M. D., Norton Memorial Infirmary and University of Louisville School of Medicine, Louisville, Ky.

Through use of photographs, designs, and printed material, the exhibit shows the progress of a specific patient, and the experiences social group work provides for her.

7. Surgery of the Colon

Drs. H. Dorton, J. Webb, M. Royalty, and Moore, Lexington, Ky.

Kodachrome photographs and latex and wax models of the vascular and lymphatic channels of the colon.

8. Pulmonary Tuberculosis, Present Day Medical and Surgical Therapy

Nathan Levene, M. D., Kentucky State Tuberculosis Sanatorium, Louisville, Ky.

- (1) Present operative treatment for pulmonary tuberculosis;
- (2) Medical therapy
 - (a) Streptomycin and PAS
 - (b) Nicotinic acid derivatives.

9. Pancreatitis

Franklin B. Moosnick, M. D., and John B. Floyd, Jr., M. D., Lexington, Ky.

Illuminated paragraph printed on frosted glass correlated with a ten-minute repeating talk on tape.

10. Self-Help Devices For Rehabilitation

Ruther A. Ryder, National Foundation for Infantile Paralysis, New York, N. Y.

The exhibit shows the use of simple equipment constructed for physically handicapped patients which enables them to perform the basic function necessary for self-care, communication, travel and other activities which are essential to the achievement of some measure of independence.

11. Rural General Practice Without a Hospital

D. G. Miller, Jr., M. D., University of Louisville School of Medicine, Morgantown and Louisville, Ky.

This exhibit illustrates a wide variety of diagnostic and therapeutic procedures that may be done by an adequately equipped general practitioner in a rural area. It shows that a small proportion of all the patients seen in an active general practice in a rural area need hospitalization and illustrates many of the procedures which are commonly done in hospitals that may be well done in the physician's office.

Busses to Stop at Auditorium

A temporary bus stop for both in and outbound traffic has been arranged in front of the Columbia Auditorium, especially for the convenience of Annual Meeting attendants.

Permission to set up the special stop was granted by the Mayor's office to the Transit Company, and the Headquarters Office is most grateful for the cooperation.

The House of Delegates will hold its first meeting at 7:30 p. m. Monday evening, October 6 at the Columbia Auditorium. Registration for this meeting and the second meeting of the House, Wednesday evening, October 8, at the Auditorium will start at 6 p. m.

Thirty Minute Intermissions have been set aside by the Committee on Arrangements for your convenience and profit in visiting the exhibits. There are a total of 72 technical and scientific exhibits you will not want to miss.

"CONVENTION CAPSULES"

The Annual Banquet will be held in the Crystal Ballroom of the Brown Hotel, at the close of the Annual Session, Thursday evening, October 9. The President's Address, entitled "Which Direction?" will be delivered by Clark Bailey, M. D., Harlan. Other features include dinner music, inaugural ceremonies, recognitions, etc. Tickets may be purchased at the Registration Cage in the Technical Exhibit Hall and the K.S.M.A. Booth in the foyer at the Columbia Auditorium.

The President's Luncheon will be one of the highlights of the meeting and will be held in the Roof Garden at the Brown Hotel, Wednesday, October 8 at 12 noon. Russ Hill, a native of Kentucky and a Detroit industrialist, will speak on the subject of "Bulwarks." Purchase your tickets at the Registration Cage or the K.S.M.A. Booth in the foyer at the Columbia Auditorium.

The Annual Public Meeting will bring state and national dignitaries to Louisville and will be addressed by Colonel Gerald M. McDonnell, Chief of the Armed Forces Special Weapons Project, Washington. You will not want to miss this important speech, which is entitled "Medical Aspects of Atomic Defense." Bring your lay friends to hear this interesting and informative talk.

Members and Guests in all categories will be registered at the Registration Cage, which will be located in the west end of the Technical Exhibit Hall at the Columbia Auditorium. Registration will start at 8 a.m. each morning, starting Tuesday, October 7 and will continue until 5 p.m. each day through Thursday.

Wabash 6903 is the Special Convention telephone number. If you wish to be reached while attending the Annual Sessions, leave this number with your home, office or hospital. This phone will be used only for incoming calls. The telephone number of the Brown Hotel is Jackson 1311.

The Woman's Auxiliary to the K.S.M.A. will hold all of its session at the Brown Hotel. Auxiliary members will register in the Lobby. The members are urged to visit the Technical Exhibits at the Auditorium.

The Scientific Exhibits will be located in the two rooms immediately to the right after entering the Auditorium through the main entrance. The exhibits will be open from 8 a. m. until 5 p. m. each day except Thursday, when the exhibits will close after the morning session.

The Check Room, located in the hall between the entrance to the Exhibit Hall and the Main Foyer, has been set up for your convenience as a new service this year.

Reference Committees will meet at the Auditorium Tuesday afternoon at 2 p.m., in the same quarters occupied by them the past two years. Any member who has any interest in any of the matters to be acted upon is urged to attend the Committee hearing that is considering the matter.

The Sixty Technical Exhibitors have been asked by the Committee on Technical Exhibits to talk only with those attendants who are wearing their registration badges. This request is made for your protection and convenience, and for that of the exhibitors. Please wear your badge at all times while in the Auditorium.

The Annual KSMA Golf Tournament will be held at the Big Springs Country Club. Golfing members are urged to bring their clubs and participate in the championship affair. You will want to play on this interesting course, scene of the 1952 PGA Tournament.

Scientific Movies, carefully selected by the Sub-Committee on Scientific Movies, will be shown continuously in the basement lounge. This room may be found by taking the stairway just outside of the Technical Exhibit Hall in the foyer.

The Education Campaign Committee will operate a booth at the north end of the entrance hall immediately outside the entrance of the Technical Exhibit Hall. This space is set aside for your convenience. You may purchase your tickets to the Annual Dinner, or President's Luncheon, or use the comfortable chairs provided to wait for a friend. The individual in charge will keep your packages for you, take your order for any of the campaign literature you may desire. This is a place to ask for any information you may desire.

Why Anemia?

HUGH JETER, M. D.

Oklahoma City, Oklahoma

Why does this particular patient of mine have anemia? Is this question out of order or too much for the physician to ask himself when he assumes the responsibility of treating any case of anemia?

Is it becoming to a physician to make false pretenses and write prescriptions, shot gun in character, containing liver, folic acid, B 12, calcium, phosphorous and vitamins, "Known and hypothetical" (Wintrobe), gastric substances, iron, copper, manganese and other metals, when in many instances much less expensive and much more specific therapy would be more efficacious?

No prerequisite to efficacious treatment is as important as the etiological diagnosis. "The anti-anemic remedies indicate the need for a clear understanding of their indications. The diagnosis should and almost always can be made before the use of therapeutic agents has obscured the whole clinical picture" (Wintrobe). It is deplorable to think of modern medicine condoning the use of shot gun remedies comparable to practices of one-half century or more ago.

Furthermore, disentanglement of the various factors, such as history, physical findings, clinical pathological reports, etc., is a challenge and no less interesting than the detection of the criminal in a detective story.

Detection of the etiological factor or factors in anemia by the following simple illustrations and measures are to be presented in the hopes of promoting and emphasizing the policy of establishing etiological diagnosis in the treatment of anemia.

HISTORY. An elderly lady, with a blood count of 1.3 million, insignificant color index and all the bizarre anatomical forms of cells that one could enumerate, had, after several visits to the office for various types of examinations, called and said, "I will be unable to keep my appointment today because I have one of those nose bleeds." Interrogated at the next visit as to the frequency of nose bleeds,

she stated that she had a nose bleed nearly every day for several years. An associate in my office had previously specifically asked her repeatedly if she had had hemorrhages anywhere in her body and she had replied negatively. She did not understand that nose bleed means hemorrhage or blood loss, the very point we needed for a diagnosis. Cauterization of the hemorrhaging areas in the nose served as specific treatment and cure in her case.

A 14 year old child had had severe anemia three or four years, slight swelling of the glands of the neck and of the axilla, a low-grade fever and a few other obscure symptoms. She had been seen by many physicians and had actually been treated at a medical center, where she had a biopsy of the lymph glands and had been given irradiated phosphorous and other new and unproven forms of treatment, all without satisfactory results. A specific etiological cause of her anemia was still a mystery and the history of the case was repeated meticulously and in connection with the questions which might indicate parasitic disease of the intestinal tract, the mother stated that three other children in the family had pin worms, but to her knowledge the patient had not had pin worms. Proper examinations of the anus and rectum revealed pin worm infestation and specific treatment for the child, as well as the other members of the family, resulted in complete cure. This case may serve to emphasize the importance of taking the history repeatedly.

A colored child with severe anemia had been treated for sickle-cell type over a period of six months, without satisfactory results. Upon questioning as to living conditions, including diet and the particular section of the city in which he lived, it was disclosed that the family lived in a two room home and that they used an old fashioned stove for cooking and eating purposes and that they obtained for fuel old batteries from a certain nearby junk yard, which was used at least in part for fuel in the stove. It so happened that this child preferred playing in the house by himself rather than out of the house with the other children.

The fumes from the lead resulted in what was found to be a typical anemia of lead poisoning. Environmental conditions as to diet and living conditions and often occupational environment must constantly be considered potential factors in anemia.

A case of moderately severe macrocytic anemia in a man 56 years of age, living in the Rio Grand Valley in Texas, who had been treated over a period of five years by liver therapy, but because of the inconvenience of the continuance of treatment wanted a review of his case. His stomach chemistry proved normal. The accuracy of the diagnosis of pernicious anemia, which had been given him, was then questioned and he was asked to be hospitalized for the purpose of examining him more carefully for intestinal parasites. He very promptly stated that he knew he had tapeworm. When asked how he knew, he said, "I have passed some segments at different intervals." Hospitalization was carried out, the tapeworm discharged, liver shots discontinued and, after three years, he has had no recurrence of anemia.

Similarly, a case of trichonosis had been studied for several years and the actual cause of anemia not found. Accidental death occurred and at autopsy muscles of the diaphragm were loaded with trichina.

A young, hypochondriacal male adult had had a moderately severe anemia for several years, responding only to transfusions. Extensive repeated examinations of all types had not disclosed the etiology. One day it so happened mention was made of aspirin which he took, and upon questioning he reluctantly admitted addiction to aspirin, taking twenty to fifty 5 grain tablets daily. Discontinuance of the aspirin lead to temporary cure of his addiction and with a normal blood picture. Incidentally, relapse into the addiction brought about the same type anemia.

Many similar cases are on record and others could be recalled by physicians in nearly all types of medical practice. The importance of history cannot be over-emphasized.

PHYSICAL EXAMINATION: Specific findings, such as extreme pallor, lemon yellow tint of the skin and the glossy tongue in pernicious anemia, the purpura in leukemia and thrombocytopenic purpura and the various, more or less specific, signs of deficiency diseases are all helpful, but perhaps more important than that

is the meticulous examination of the patient for evidences of constitutional disease, such as may be responsible for the condition of anemia.

An 8 year old Mexican boy had had a diagnosis of severe anemia, with a hemoglobin of 43% and rbc's 2.2 million and had innumerable, slightly elevated nodules throughout his scalp. Further investigation revealed destructive lesions of skeletal system, characteristic of Hutchinson's type neurosarcoma. In such a condition there is actually subperiosteal metastasis and, although tumor cells are found in the subperiosteal spaces, the great volume of cells are extravasated red cells and the patient, therefore, hemorrhaged subperiosteally to the extent that he had a blood loss anemia.

A case of a 65 year old male, with thirty-five pounds weight loss over a period of six months, a very slight enlargement of the liver and a severe microcytic, hypochromic anemia, had been treated several months for anemia. A small supraclavicular node was found and the biopsy lead to the diagnosis of carcinomatosis.

A 45 year old female, with a hypochromic, microcytic anemia apparently responded very satisfactorily to iron therapy, but upon repeated physical examination a mass was found in the right lower quadrant. Previous x-ray studies had been negative, but having located the mass, a repeat examination revealed a constant defect, which proved to be carcinoma.

Malignancy cases have purposely been emphasized in connection with physical examination, because of the frequency of anemia associated with malignancy. Very few cases of malignancy fail to become anemic.

Splenomegaly is an important physical finding in connection with hematological diagnosis. Icterus, splenomegaly and a hereditary history occur as a striking group of symptoms and may even justify a snap shot diagnosis of familial hemolytic jaundice. A splenomegaly and idiopathic type anemia frequently ultimately develop into leukemia in cases where at the onset hematological studies are not decisive. The well known splenomegaly and anemia of chronic malaria are frequently observed in malarial districts.

Lymphadenopathy, whether regional or generalized, is of considerable importance in connection with various diseases, such

as lymphosarcoma and Hodgkin's disease, etc., which commonly lead to anemia.

To further enumerate detailed illustrations and examples of the importance of physical examination is not feasible, but insistence that every patient who has anemia without a working etiological diagnosis should be subjected not once but frequently to complete detailed physical examinations, should be routine. The rewards are sure to pay for the effort.

X-Ray. Diagnostic x-ray procedures are mentioned separately, with the thought that it is worthy of emphasis. The above mentioned case of neurosarcoma well illustrates the importance.

Old people harboring chronic infections of various types are frequently anemic. A 75 year old man had been treated parenterally triweekly with liver, had had shot gun mixtures of iron, liver and vitamins daily and, altogether, as the referring physician stated, "had been treated intensively for anemia." A roentgenogram of the chest showed active pulmonary tuberculosis. Such a finding is unusual in a man of his age and was difficult to elicit by physical examination.

A macrocytic anemia, which did not respond to liver therapy, had x-ray studies of the gastrointestinal tract, with negative findings, again and again, but finally a carcinomatous lesion of the cardia was demonstrated. The gastrointestinal tract often proves to be a primary site of malignancy in cases which have been anemic over a considerable period of time, without specific symptoms relating to the offending lesion.

A plumber had been taken from his occupation and treated for some time for anemia, presumably lead poisoning. He had no symptoms relating to stomach or gastric distress, but x-ray studies showed a comparatively large lesion located in the middle one-half of his stomach and resection proved the specific treatment for his anemia.

A case of thrombocytopenic purpura, which was considered idiopathic, showed extensive skeletal lesions characteristic of primary carcinoma of the prostate. Hormone therapy in large doses over a short period of time completely relieved his purpura and blood loss anemia, which had resulted from hemorrhages of the bladder and rectum and gingiva. His general condition has remained good after three years of continuous oral therapy. A shot gun

capsule loaded with iron, liver, folic acid, vitamins, copper and what have you, did not serve the purpose in this case.

CLINICAL PATHOLOGICAL EXAMINATIONS. First of all, it is not apropos to ask, is the patient actually anemic?

A group of sixty sophomore University of Oklahoma Medical School Students had hemoglobin determinations taken under three separate circumstances:

1. At 8:00 in the morning, without fluids or breakfast. This yielded an average of 99.8% (15.1 gms—100%) hemoglobin.

2. Immediately after blood had been taken for the test they were each given one quart of fluids and one-half hour later the same test, by the same instrument (Sheard-Sanford photometer), the average hemoglobin was 91.6%.

3. The following morning after having a normal breakfast, the average was 96%.

This illustrates the importance of the state of hydremia in consideration of anemia, or if anemia, what degree of anemia.

Wilson, in his work recently, has shown that something like 90% of the cases of apparent anemia of pregnancy is actually an increase in blood volume and at the end of the course of pregnancy their blood count, by ordinary methods, returns to normal. Dieckman and Wegner have shown the average increase in blood volume at term is 23%, while the plasma volume is increased 25%.

Erlanger, Rowntree, Brown, Roth, Peters and Van Slyke have all directed attention to this physiological state and more recently, since the Evans blue dye test has become practical, blood volume determinations are worthy of consideration, not only in pregnancy, but in a few other conditions, as follows: Splenomegaly, scurvy, cirrhosis of the liver, hypothyroidism and other diseases.

In short, there are instances when the blood volume may prove the patient not to be actually anemic when the ordinary methods of hemoglobin and red count determinations indicate anemia.

Specific laboratory findings helpful in establishing the etiological background of anemia need only be enumerated: Macrocytosis is suggestive but not necessarily pathognomonic of pernicious anemia, tape worm infestation, lesions of the gastrointestinal tract (carcinoma of the stomach, stricture resections, anastomosis, ob-

struction, diarrhea and steatorrhea), pelagra, certain anemias of pregnancy, and certain idiopathic diseases or deficiencies leading to deficiency of the erythrocyte maturation factor.

An absolute spherocytosis is almost pathognomonic of congenital icteric anemia.

Sickle cells are specific for certain traits and anemias.

Erythroblastosis with sudden onset in children or young adults is invariably Lederer's anemia, a very rare type.

Macrocytosis and hypochromia is often strong evidence of liver disease.

Stippled hypochromic microcytic cells are invariably the result of lead poisoning.

Anemia without morphological changes of the erythrocytes is almost certainly aplastic.

Hypochromic microcytic types of cells are found in a large variety of so-called secondary anemias and in this class more than in any other, evaluation of factors other than the laboratory findings, such as mentioned above are of utmost importance.

The white cells not infrequently give a clue to the type of anemia. For example, a case of idiopathic microcytic, hypochromic, chronic anemia developed a persistent hypossegmentation of the neutrophils, with some toxic forms, indicating generalized toxemia. Further investigation revealed polycystic kidneys and uremia. Interrogation brought forth a history of polycystic kidney of a brother and one of the parents.

Hypersegmentation of the neutrophils goes with pernicious anemia.

The persistence of 10% or more of basophils, or 15% or more of myelocytes, or the blast forms of neutrophils is direct evidence of leukemia, and anemia is a constant companion of the acute and sub-acute leukemias.

Lymphocytosis, either relative or absolute may indicate chronic infection, is consistent with lymphosarcoma or Hodgkin's disease and in such instances where there is 10% or more smudge cells or lymphoblasts, lymphatic leukemia is a probability.

Eosinophilia may be directly significant as an indication of leukemia, is sometimes associated with intestinal parasites, is

often the result of parenteral injections and not infrequently associated with hidden chronic infection of undetermined location.

Thrombocytopenia, especially in event the individual thrombocytes are qualitatively immature, is direct indication of bone marrow inadequacy and if the erythroblastic system has not failed, failure may be safely predicted if the condition causing the thrombocytopenia is not corrected.

Bone marrow biopsies are considered by the average clinical pathologist not to be as accurate or as specific in connection with a diagnosis as an ordinary tissue biopsy. However, this procedure is helpful and at times indicated, especially in the following: Leukopenic leukemias, hyperplastic anemia, Gaucher's disease, multiple myeloma, pernicious anemia and, in most of the anemias in which repeated peripheral blood studies fail to indicate the etiological diagnosis. In cases of carcinomatosis, malignant cells can occasionally be identified. Malaria plasmodia have been found at times when it was impossible to find them in the peripheral blood stream. A baby only two weeks of age was found to have extremely severe microcytic hypochromic type anemia with no history or clinical findings to indicate malaria. Routine bone marrow studies disclosed malaria plasmodia. Diseases too numerous to mention may rarely have significant findings within the bone marrow.

CHEMICAL EXAMINATIONS: Aside from direct hematological studies, certain indirect examinations, such as the gastric analysis, are important. For practical purposes it is safe to conclude that pernicious anemia does not exist in the presence of normal free hydrochloric acid in gastric contents.

Hemoglobinuria and urobilinogen determinations and other tests of urine have great significance.

Stool examinations for blood, parasites and pus are routinely important.

Many other tests may be specifically indicated in each individual case.

FOLLOW-UP: No patient should be dismissed until a satisfactory etiological diagnosis has been made. Many cases require much time and patience before this goal is reached. Cases have already been recited vividly illustrating this point. It

may, therefore suffice to say that careful follow-up is most important in diagnosis in all types of diseases and none the less important in cases of anemia.

Response to specific therapy in the case of pernicious anemia must be regarded as a very important factor in the establishment of the final diagnosis. However, in most instances of anemia the therapy is not specific and, therefore, can not be regarded as a diagnostic procedure thoroughly dependable.

Summary

Simple clinical and laboratory factors have been recited in the hopes of emphasizing not only the importance of etiological diagnosis, but the feasibility of arriving at a good working diagnosis. Whether the case is to be cured or not, the

over all management is most satisfactory with specific treatment. An anatomical diagnosis of anemia is not sufficient.

Is it, therefore, too much for the physician who is treating an anemic patient to keep constantly in mind, why does this patient have anemia?

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Ionizing Radiation Injury From Atomic Bombs

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Ionizing radiation injury has been variously estimated to have accounted for only 7 to 39 per cent of deaths from the high air detonations of atomic bombs in Japan, but the problem is still of importance in view of the fact that 15 per cent (the "official" estimate) of about 60,000 deaths in one city is 9,000 deaths!

The effects of ionizing radiation have long been known (1). Whether from alpha, beta, proton or neutron particles, or gamma or x-rays, the effects on tissues are qualitatively similar. Depth and intensity of injury differ with each source of radiation and with the energy.

Ionizing radiation changes are injurious and are easily classified pathologically as cellular, intercellular, and vascular. The effects of other agents, either physical (heat on collagen), chemical (colchicine on cell nuclei) or biological (syphilis on endothelium), mimic these changes. The larger the amount of radiation absorbed, the faster the absorption, and the larger the volume of tissue irradiated, the greater the injury. Various tissues respond

differently to an equal quantity of radiation. A listing of tissues arranged in the order of decreasing sensitivity to radiation injury appears in Table I.

TABLE I

Adult Tissues Listed in Descending Levels of Radiosensitivity

1. Hemopoietic, including lymphoid, tissues
2. Intestinal glands
3. Gonadal epithelium
4. Skin epithelium
5. Endothelium
6. Fibrous tissues
7. Internal epithelial organs
8. Cartilage and bone
9. Muscle
10. Nervous tissue

Almost all this knowledge has been derived from experience with the focal or localized area type of irradiation that has long been used in therapy. With focal radiation, consideration need only be given to the lesion and the normal fixed tissues around it, except for the diseased tissue, although systemic reactions to the stress may also obtain. For instance, in the forearm the tissues necessary for continuing function are fairly resistant to

From the Armed Forces Institute of Pathology. Read before the Ephraim McDowell Memorial Meeting, the Centennial of the Kentucky State Medical Association, Louisville, October 2-5, 1951.

radiation. Even the loss of function of a part may not be of great importance in relation to the economy of the integrated body. Many areas are radioresistant. Moderately high dosage to a muscular area is required to destroy the muscle and the function it performs. However, the brain, the nerve cells of which are highly radioresistant, can withstand only that amount of radiation which will not so injure its vascular network as to result in nutritional interference and subsequent areas of degeneration of nerve cells. Although 5,000 roentgens might be an ordinary dose of x-radiation to the lower leg, one tenth of this dosage, 500 r., delivered to the entire body would probably result in death.

Acute ionizing radiation absorption throughout all the body, often called "total body radiation," requires an entirely different approach in evaluating the damage. Since every tissue is potentially affected, consideration of the relative importance of each tissue in the order of decreasing radiosensitivity as shown in Table I is paramount.

Because they are so widely distributed and have such fundamental functions, it turns out that the integrated organism is only as strong as its hemopoietic elements, the most radiosensitive tissues of the body. In the Japanese casualties (2) there was evidence of rapid and spectacular decrease in bone marrow and lymphoid cells throughout the body. This led to a decrease in cellular content of the peripheral blood, manifested often as a striking leukopenia as early as the second day, and a slower but progressive oligocythemia. With diminished leukocytic elements, defense against infection suffered, and clinically recognizable infection of wounds and burns, neutropenic necroses of the oropharynx, lungs, intestines, and distal genital tract reached their peaks in the third to sixth weeks. Anemia became profound in the second and third months. The thrombocytopenia aided in producing a striking hemorrhagic syndrome of multiple widespread petechiae or small ecchymoses, which began to appear in the second week, reaching a height about the fourth week. By transfusions of fresh platelets Cronkite (3) has succeeded in preventing the hemorrhagic phase in dogs given lethal total body radiation. These changes are manifestations of aplastic anemia from total body ionizing radiation as has been previously suggested (4).

Regenerative attempts by the relative-

ly resistant reticulum cells or histioblasts are seen in the first week both in the bone marrow and in the lymphoid tissues. These cells are so changed, however, that they "forget how to reproduce normally" (5) and instead of granulocytic cells their progeny temporarily are lymphoid and plasma cells. After three months, active restoration of all hemopoietic cells to normal numbers was the rule in survivors.

In the next level of radiosensitivity the epithelial cells in the crypts of ileal glands showed injury during the first two weeks, when a few small ulcers were also found. Ulcerative and pseudomembranous changes became common after the third week and were observed even in the third and fourth months. The colon, less radiosensitive than the ileum, usually contained these lesions. It seems then that the intestinal ulcers or pseudomembranes, perhaps initiated by direct ionizing action, were mostly secondary to the hemopoietic breakdown which allowed ordinarily nonpathogenic intestinal flora to produce a picture often simulating that of *Shigella* dysentery. Hemorrhages that broke down also led to ulceration.

The third most radiosensitive tissues, the reproductive organs, appear to have sustained direct radiation injury to the spermatogenic and follicular cells, which, however, was apparently temporary. These changes seemed to have little influence on survival of the individual patient. Hemorrhages in these organs could be regarded as secondary to the hemopoietic defect.

In the skin, the fourth most sensitive tissue listed, the hair follicles were directly affected by radiation, epilation being the prominent result. A high rate of ulceration of unburned or perhaps slightly traumatized skin was in evidence; again apparently secondary to the disturbed capabilities of an injured hemopoietic system.

Although listed in fifth place for morphologic injury, there is some indication that the endothelial function was so radiosensitive as to allow vascular permeability of such order that fluid and red blood cells escaped into the tissues. There was a changed fluid content of the blood as evidenced by hemoconcentration and edema, particularly in lymph nodes, stomach, intestines, and lungs. From studies on experimental animals, Furth (6) has suggested that increased capillary per-

meability brings about a diversion of red blood cells from the blood vascular system to the lymph channels. Tullis (7) has shown erythrophagocytosis in lymph nodes of Bikini animals, and Eaton (8) has found striking erythrophagocytosis in lymph nodes in less than an hour after total body LD 50 x-radiation of dogs. Consonant with this concept, some grossly red lymph nodes with red blood cells in their sinusoids (9) appeared in Japanese casualties. Dilated capillaries in their pharyngeal and intestinal tissues also suggested direct radiation effect on endothelium. What part of this hemorrhagic syndrome was hemopoietic and what part endothelial in origin is obscure.

In the tissues listed as less radiosensitive, changes caused directly by ionizing radiation were indistinct. Secondary changes, such as hemorrhage, edema, bacterial invasion, neutropenic necrosis or other acellular inflammations, occurred within all tissues except cartilage and bone.

SUMMARY

Tissues of human casualties of atomic bomb explosions were injured directly by

ionizing radiation in proportion to their radiosensitivities. The total body effect was caused largely by injury to bone marrow and lymphoid elements, as evidenced by hemorrhage, infection by organisms ordinarily non-pathogenic, and by neutropenic necroses and acellular ulcerative and inflammatory processes involving particularly all external and internal linings—all manifestations of aplastic anemia.

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Acute Idiopathic Pericarditis Treated With Cortisone

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The treatment of acute idiopathic or non-specific pericarditis is usually symptomatic or expectant. Although antibiotics have been used with apparent success (1, 2, 3, 4), most authors agree that there is no specific treatment, (5, 6, 7, 8, 9, 10).

The following case is the first reported treatment of this disease with cortisone with subsequent amelioration of all symptoms and signs.

Case Report

W. H., a sixty-one year old male, was first seen at 12:30 a. m. on November 6, 1951, because of a sudden severe pain under the upper end of the sternum with radiation down to the xiphoid process. The pain disappeared in about two hours after two doses of 100 mg. of demerol, an hour apart. From then on, during the en-

tire illness, there were no subjective complaints.

For the previous two weeks he had had a cough, moderate expectoration and generalized malaise.

Physical examination of the heart was normal, except for a rate of 120 per minute. Signs of pneumonitis were present at the left lung base.

Twenty-four hours after the onset of the pain, a pericardial friction rub was heard over the precordium. This persisted with varying intensity and distribution over the chest until December 9, thirty-three days later.

The blood pressure was 150/90 during the pain but thereafter ranged from 140-120/80-70, which was his usual blood pressure.

Except for an occasional elevation of the

temperature to 100.0° F., he was afebrile during the entire illness.

Electrocardiogram Report

The electrocardiogram taken twelve hours after the onset showed low voltage inverted T waves in lead I, which were present in an electrocardiogram made as part of a periodic health examination in 1946. Subsequently, minor abnormalities of the T waves appeared in various leads but the classical pericarditis pattern did not appear. Records were made at weekly intervals. One day after the onset, auricular flutter was present. After fifteen grains of quinidine sulphate in eight hours, normal sinus rhythm was present. In the following month, two attacks of auricular fibrillation were clinically noted. Normal rhythm was again established in six hours with twelve grains of quinidine. The patient was never conscious of the disturbance in the rhythm.

Blood Count Picture

A complete blood count made two weeks after the onset was normal, as were two subsequent counts. Three weeks after the onset, the sedimentation rate was 42 mm. in an hour. It was the same a week later. Urinalysis was normal. Agglutination tests for undulant fever, tularemia and cold were normal. The heterophile agglutination showed a titer of 1-28. A blood culture was sterile. The Kahn test was negative.

X-Ray Examination

Several x-ray examinations of the chest were made. Twelve hours after the onset, fluoroscopic examination of the heart was normal. At the base of the left pleural sac, a slight shadow was noted, either fluid or a thickened pleura. Three weeks after the onset an x-ray of the chest showed the heart to be enlarged to the right and left. At the base of the left pleural sac there was elevation and straightening of the shadow of the diaphragm which was not definitely visualized and there was either pleuritis or a small amount of fluid, or both, at the base of this pleural sac.

Treatment

Three days after the onset, he was given aureomycin, 0.5 gm., orally, every six hours for two days, then 0.25 gm. every six hours for five days. There was no

change in the intensity and distribution of the pericardial friction rub. Terramycin was then administered, 1 gm., orally, every six hours for two days, then 0.5 gm. every six hours for five more days. Again, no change was noted in his condition. This was followed by streptomycin, 0.5 gm., parenterally, twice a day for a week without any improvement. He was finally given cortisone, 100 mg., orally, every eight hours for three doses, then every twelve hours for a week. Within thirty-six hours the pericardial friction rub became less intense and at the end of eight days, the rub could not be heard.

Five weeks after the onset, on December 14, the patient became ambulatory. Fluoroscopic examination of the chest was similar to that of November 27, but a week later the heart was normal in size and shape, although the shadow in the left pleural sac remained unchanged.

Etiology

Pericarditis can be due to a variety of causes, the most common being tuberculosis, rheumatic fever, myocardial infarction, trauma and the terminal stages of uremia. It has been found associated with numerous other conditions (11): pneumococcal infections, allergy, primary atypical pneumonia, upper respiratory infections, lymphogranuloma venereum, rheumatoid arthritis, tularemia, amebiasis, disseminated lupus erythematosus and cancer, not to mention all. This patient had no disease known to cause or be associated with pericarditis, hence the diagnosis of acute idiopathic or non-specific pericarditis.

Conclusion

This is a report of the first case of acute non-specific or idiopathic pericarditis in which, following the oral use of cortisone, all symptoms and signs disappeared. It was effective when aureomycin, terramycin and streptomycin were ineffective.

Since this report was submitted, I have treated with cortisone another case of acute non-specific pericarditis with equally gratifying results.

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Psychosis With Myxedema

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The following case demonstrates a psychotic reaction due to endocrine imbalance that closely simulates a so-called "functional" psychosis, Schizophrenia. Psychoses with myxedema are comparatively rare and frequently unrecognized. A perusal of half a dozen current psychiatric textbooks disclosed that this clinical entity was entirely ignored in three texts and only a brief paragraph devoted to it in the remaining three. Noyes (1) in his textbook, "Modern Clinical Psychiatry," mentioned that "mental changes are noted in myxedema in the form of slowness, retardation, difficulty comprehending, indifference, memory impairment, irritability and paranoid trends determined by emotional and personality factors." Bleuler's (2) "Textbook of Psychiatry," described myxedema as characterized by dry, thick, puffy skin, swelling of the mucous membranes, loss of hair and cold extremities.

Symptoms

The facial expression appears stupid, movements are slow and the voice grating. Sensibility is dulled and paresthesias develop, especially headaches and the feeling as if the limbs have gone to sleep. There is retardation of the processes of thinking, of decision and the translation of the latter into movement. Memory for recent events is bad. The patient may become depressed. Distrust may arise to the extent of delusions. In severe cases, illusions and hallucinations of hearing, sight, smell and taste also occur. Severest cases finally develop hallucinatory confusions, coma and convulsions.

Infrequency

The infrequency of this condition was emphasized by Crowley (3) who found

only two patients who could be classified as "psychosis with myxedema" out of 4500 mental hospital admissions over a fourteen year period. Asher (4) in 1949 described fourteen hospitalized cases of myxedema with psychotic changes. In nine cases, dramatic and complete recovery of sanity occurred with thyroid therapy. In two cases, there was partial improvement, one showed no change and two died. In none of the cases had the diagnosis been made by the referring physician, suggesting the increased need for awareness of myxedema as a cause for psychosis.

Differentiation

Akelaitis (5) in 1936 stressed the fact that a differentiation must be made between mental disturbances occurring as a coincidental factor in the course of myxedema and mental disturbance arising during the myxedema and dependent on it. In the latter, administration of thyroid results in the disappearance of physical and mental symptoms. The same author pointed out that there is no specific type of psychosis associated with myxedema. His study of the cases reported in the literature pointed to a delirious hallucinatory type of reaction most frequently observed. This was a variable picture with clouding of consciousness, dream like disorientation, hallucinations of the various senses, most frequently visual. Unsystematized delusions of persecution, excitability and difficulty in coordinated movements were common.

Zondek and Wolfsohn (6) in 1944 described a case of psychosis with myxedema that had previously been mistaken for Schizophrenia and had received insulin and convulsive therapy without im-

provement. Dramatic recovery took place after a few days of thyroid therapy.

The purpose of this report is to emphasize the importance of being aware of this clinical entity as it may assume many different forms and is usually first seen by the general practitioner or non-psychiatric specialist.

Case Report

A 21-year old married woman was admitted to Our Lady of the Oaks Hospital, Lexington, on January 12, 1952 by transfer from a hospital in eastern Kentucky. Admission history obtained from the father, a coal miner, was meagre. He stated that since the birth of her last child, two years ago, his daughter had been getting increasingly "nervous." She complained of pains in the legs, neck and stomach. She was depressed, had frequent crying spells and worried excessively. She had become progressively weak and was unable to do any housework. The father had taken her to several physicians without improvement. More recently, she had become withdrawn, irritable, confused, thought people were trying to harm her and experienced both visual and auditory hallucinations. She remained in bed most of the time and disregarded the responsibilities of the home and children.

History of Case

The patient was an only child. Both parents were in good health. Early medical history was uneventful. Development was normal and she was considered a bright child. She completed two years of high school and married at the age of 15. This proved to be an unhappy venture as her husband drank excessively, was unfaithful and was sentenced to the penitentiary for forgery at the time the second child was born which coincided with the beginning of the patient's illness. She had two children, ages 4 and 2. The patient had been living with her parents since her husband had been imprisoned.

Case History

On admission, the patient appeared well nourished but pale and apathetic. Temperature was 99, pulse 88, respiration 20, blood pressure 116/80, weight 118 lbs. There was moderate supraorbital edema and the lips were dry and scaly. Breath was foul and post nasal discharge was

present. The thyroid was not palpable. Heart and lungs were negative. Palpation of the abdomen outlined the cecum and pain was experienced in both lower quadrants. Pelvic examination disclosed a normal cervix, slight enlargement of the uterus and a profuse vaginal discharge, characteristic of trichomonas. The rectum, as felt from the vagina, was packed with feces. The extremities were negative aside from dryness of the skin. Neurological examination was entirely normal.

Psychiatric Status

The patient complained of nervousness, fatigue, depression and impaired memory of two years duration, progressive in nature. She was lethargic, responded slowly to questions and her voice had a nasal quality. Facies was expressionless and fixed without any response to affective stimulation. She appeared withdrawn, preoccupied and somewhat perplexed. She could not recall entering the previous hospital and had amnesia for events preceding hospitalization. She was disoriented as to place and time. She thought that people were trying to kill her and felt threatened by the physical examination to which she reacted with negativism. She mentioned hearing voices continuously which confused and alarmed her but she would not discuss the content of her hallucinations. During the examination her eyes roved about the room and toward the ceiling in response to the hallucinations. Insight was limited to the fact that she recognized something was wrong with her. The clinical impression was Schizophrenic reaction with catatonic and paranoid trends.

Laboratory Data

RBC: 3,260,000, WBC: 6500 with 54% lymphs and 46% polys, Hemoglobin: 55%, NPN: 16 milligrams, Urine: negative, Skull X-Rays: negative.

The Rorschach test confirmed the diagnostic impression of Schizophrenia.

Observation of Patient

The patient was observed for several days, during which time she remained disinterested and listless, sitting in a chair for hours at a time, totally ignoring her environment. She talked only when coaxed and then complained of pains in her legs and abdomen. She refused medication and appetite was poor. Her confusion and hallucinations continued unabated. During interviews, the patient

was irritable and suspicious and made it apparent that she preferred not to be disturbed.

On January 16, 1952 an electro-shock treatment was administered, using standard technique. Immediately following the convulsion, difficulty in breathing was encountered due to obstruction caused by the tongue. At this time it was noted that the tongue was enlarged and edematous and the diagnosis of myxedema then became apparent. The other physical findings, such as, hoarse voice, dry skin and lips, supraorbital edema and secondary anemia became more meaningful. In the light of her hypothyroidism, the patient's retardation, paresthesias, fatigue, confusion and memory impairment were typical. The delusional thinking, hallucinations and flattened affect had been misleading in emphasizing the functional nature of her illness, as well as the psychological circumstances under which her illness had developed. The normal pulse and blood pressure were not typical of myxedema.

Result of Thyroid Treatment

On January 17, 1952 the BMR was -21%. An EKG was interpreted as indicating myocardial disease. The patient was placed on thyroid extract and rapidly built up to 8 grains a day. On January 29, 1952 and February 7, 1952 the BMR was -11%. Clinical improvement began to take place within a week and in three weeks the patient was alert and in good contact. She socialized with the other

patients, spoke more freely and could recall the events of her illness. Paranoid ideation disappeared but the auditory hallucinations persisted in mild form. The edema of the eyelids receded, her voice lost its hoarse quality and the lips and skin assumed a more normal texture. A weight loss of 4 lbs. occurred. The patient was discharged on February 13, 1952 after 32 days of hospitalization with instructions to use 6 grains of thyroid daily. On a follow up visit one month later, improvement had been continuous. There were no physical manifestations of myxedema and the patient had assumed her premorbid personality and activities without any evidence of psychosis.

Summary

A case of psychosis with myxedema is described which closely resembled a functional psychosis, Schizophrenia. Physical and psychological manifestations cleared up in a few weeks with thyroid therapy. The tendency of myxedema to be reflected in diverse psychotic reactions should be kept in mind.

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Special Article

THE ROLE OF THE GENERAL PRACTITIONER IN CIVILIAN DEFENSE

THOMAS V. Z. GUDEX, M. D.*

Louisville

The following is an excerpt from Volume II, No. 1 of The Civil Defense ALERT: "BOMB CASUALTIES MIGHT REACH 7,500,000 TOTAL New York.—Based on the best available intelligence estimates, it is now believed that 'a smashing all-out attack on our home front could produce a possible 7,500,000 casualties from the effects of atomic bombs,' Federal Civil Defense Administrator Millard Caldwell told the twentieth anniversary session of the United States Conference of Mayors.

'That is the medical problem that we ought to be prepared to face,' the Administrator said. 'If we had 7,500,000 Casualties from A-bombs, approximately 5,000,000 of those would survive the first 24 hours. We are nowhere near being ready with the supplies and equipment needed to care for that many casualties.

'If we don't take prompt action to get ready to handle the medical and other civil defense problems, we are laying ourselves open to the kind of crushing attack that would make Pearl Harbor seem as disastrous as the bruised knees and cut fingers at a Sunday School picnic.'

The above is a very concise description of the civilian defense problem in our country at THIS TIME.

The General Practitioner is the keystone in the arch of the medical care of the sick and the injured. This is true at all times whether in peace or war but especially in the field of Civilian Defense. Who does the average layman call in any emergency? The local general practitioner!

It has been stated that one of the main target areas in the state of Kentucky, in the event of an atomic attack, is the metropolitan area of Louisville. About 1/3 or more of all of the physicians in Louisville would be classified as specialists. It has been estimated that 1/2 to 3/4 of all of

the physicians in "down town" Louisville, in the case of a daytime raid, would be casualties; therefore, in order to obtain medical personnel to carry on during the resulting disaster the physicians from the fringe or outer portions of Louisville and the surrounding rural areas would be called on to help.

According to long term planning of our government, Federal, State and local, mobile medical units from as far as Paducah, Bowling Green, Lexington and Ashland would or should be available at all times to be alerted and transported to the fringe portions of the disaster area to man emergency hospitals or aid stations.

The over all plans for such an emergency or disaster at present are progressing fairly well. The formation of mobile units with medical and nursing personnel on a state level are in the process of formation and do not have only a paper framework. The Committee on Emergency Medical Service of the KSMA would like to be certain that they can rely on the members of the KSMA for their wholehearted support and aid in the formation of these units.

This message is primarily addressed to the General Practitioners of Kentucky and especially to those above military age who are actively engaged in the practice of medicine and surgery. If you know little or nothing about Civilian Defense or feel that the danger of atomic attack is not real or insignificant or far off in the distant future, then I would suggest that you read a little about Civilian Defense in the literature which is available in the office of our KSMA. If and when you (or should you have already done so) organize your local Civilian Defense set-up in your own area you will discover that such an organization does not have to function only in atomic warfare but

(Continued on Page 406)

*Member of Committee on Emergency Medical Service.

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THE MEDICAL PROFESSION IN KENTUCKY HONORS THE GOVERNOR'S REQUEST

In response to Governor Lawrence Wetherby's appeal to President Clark Bailey, asking for the active cooperation of the Medical Profession in the organization of the Profession in the State's Civil Defense Effort, effective efforts on a number of fronts have been made by officials and agencies of the Kentucky State Medical Association with gratifying results.

The Committee on Emergency Medical Service has held four meetings with almost perfect attendance since the first of the year. These sessions have been attended by Federal Civil Defense officials from Washington and Cleveland, and the State C-D organization has been represented at each session. Deep consideration was given during the blue-printing stage to the best way to mobilize the medical resources and now these carefully laid plans are being implemented.

The Committee, following the request of state officials, has set up a medical unit for each of the four mobile support districts. While only one was asked for the district embracing Louisville, a second is being organized. In addition, an independent group is being established at Lexington. Each member of the Committee has a specific assignment in this effort.

The Committee on Scientific Assembly, acting in cooperation with the Governor's wishes, has scheduled a symposium on the Treatment of Atomic Illnesses for the Third Scientific Session of the Annual

Meeting, Wednesday morning, October 8. Leading medical authorities in the Federal C-D setup from Washington will participate along with a Colonel in the Medical Corps, just returned from Korea, who will discuss treatment of battle casualties.

The Committee on Arrangements, seeing the opportunity to broaden the impact of the Profession's effort on the public, has scheduled an address for the Annual Public Meeting, Tuesday evening, October 7, on Radiological Defense by a high official in the Army Medical Corps. The recent Nevada atomic tests will provide the background of what this experienced lecturer will have to say.

To further bring to the public a broader realization of the need for proper preparedness, efforts are now under way to arrange programs on Louisville's television and radio stations, featuring the prominent out-of-town C-D authorities. Efforts will also be made to give their utterances broad press coverage.

A well-known physician and law-maker, Congressman Judd, told a recent audience at the A.M.A. meeting in Chicago, that aggressor nations in World Wars I and II lost their campaigns because of American productivity. He said we can be assured that in World War III, every effort will be made to destroy America's war potential first. We think Kentucky and her Governor can be proud of the efforts of the Medical Profession to meet this threat.

SPENDING YOUR TIME WITH THE BEST

When you attend the Annual Meeting this fall, and visit the technical exhibit hall, you can rest assured that your Committee on Technical Exhibits has exercised every care to admit only organizations whose products meet the highest standard as exhibitors.

Our state is one of the fourteen states that accept only those companies whose products are "council accepted," according to a recent survey in which 41 states participated and which was conducted by the Indiana State Medical Association.

Council Accepted means that the product has passed the rigid tests prescribed by the respective council of the American Medical Association the product is considered, by. When the A.M.A. puts its stamp of approval on a product, you know that the product is reputable and its virtues not exaggerated.

Moreover, Council Accepted companies who do us the kindness of exhibiting at our Annual Meeting appreciate the fact that they are not forced into a position of competing, perhaps, with just any com-

pany willing to pay the rental fee for a booth. Our exhibitors are interested in seeing that the highest standards are maintained.

As this Committee has ardently sought the company which makes only the highest quality products as a technical exhibitor at our meeting, it also has enthusiastically urged the members of our Association to visit each exhibitor booth during the meeting. Different companies have different ways of measuring interest at these meetings—all of them effective. If the members are not interested in attending the booths, the companies lose interest in buying space at the Association's meetings.

If you do not visit these booths, you deny yourself an opportunity to get the latest and best information in the field of medicine, instruments, equipment, litera-

ture and the various services. You have no other opportunity that compares with this one in the matter of acquainting yourself with products and services you should know about in order to be informed of the latest developments. You will find it highly profitable to visit with the courteous, highly-trained specialist, who will man the booths at our meeting this fall.

Your Committee on Technical Exhibits appreciates the cooperation the membership has shown the exhibitors at our meetings in the past. Your continued support will not only reflect credit to our membership, but will add many to the number who are already of the opinion that our Association has, perhaps, the best technical exhibit hall in the South.

COMMITTEE ON TECHNICAL EXHIBITS
Carlisle R. Petty, M. D., Chairman

OBSERVATIONS RELATING TO THE USE OF GAMMA GLOBULIN IN PREVENTION OF PARALYTIC POLIOMYELITIS

Whether gamma globulin will be effective in the prevention of paralytic poliomyelitis is not now known. On the basis of animal experiments and preliminary study on humans, it is possible that globulin will have value in human poliomyelitis, but serious questions remain to be answered before such a hope can be substantiated. Nevertheless, public dissemination of information on the status and objectives of current studies, incompletely presented or misunderstood, has created a serious demand for gamma globulin which cannot be met.

Virtually the entire output at current production rates is required to meet the demand for prevention or modification of the course of measles and infectious hepatitis.

Under the circumstances, it is obvious that the existing limited supply and current production of gamma globulin should be reserved for use in these diseases in which its efficacy has been established.

GEORGE F. LULL, M. D.
Secretary and General Manager, AMA.

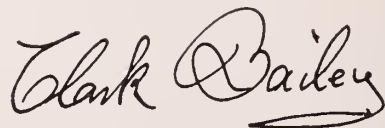
President's Page

The program of the annual convention of the Kentucky State Medical Association which is to be held October 7, 8 and 9, at Louisville, promises to be most outstanding. Many prominent leaders of scientific medicine in the United States, as well as those in our own state of Kentucky, will participate. Seldom is offered such a well-balanced presentation of medical subjects by leaders in their respective fields.

Special emphasis at this convention is given to the field of atomic and catastrophic medicine. The public meeting, Tuesday evening, October 7, will feature an address by Colonel G. M. McDonnell, who has gained special recognition because of his work in atomic medicine. His most recent investigation in this field was in connection with the tests and experiments held on the Utah flats.

The Wednesday morning program will pertain to subjects relative to catastrophic medicine. In addition to the discussion of atomic bomb casualties, the management of casualties in Korea will be reviewed by Colonel Frank E. Hagman who recently returned from Korea. This portion of the program is related to the work of our Committee on Emergency Medical Service and our responsibility as doctors to the program on Civil Defense.

The officers of your Association have made every effort to bring to your annual convention the best possible program of instruction in the advances of medicine. An unusual array of scientific talent is to be presented for your benefit. The opportunity for scientific development is yours. Make every effort to attend the convention October 7, 8 and 9.

A handwritten signature in cursive script that reads "Clark Bailey". The signature is written in dark ink and is positioned above the printed name.

PRESIDENT

ORGANIZATION SECTION

KSMA to Participate in Diabetic Detection Drive Nov. 16

Kentucky will again participate in the National Diabetic Detection Week program, November 16 to 22, Carlisle Morse, M. D., Louisville, Chairman of the K.S.M.A. Committee on Diabetes, has announced.

Each County Society has been asked by President Clark Bailey to appoint a County Diabetic Committee and a great percentage of the organized County Medical Societies are co-operating. According to Dr. Morse, each County Medical Society will be encouraged to organize their own county for the Detection Drive. His Committee, working through the Headquarters Office, will offer the county committee every assistance possible.

Dr. Morse expressed himself as being well pleased with the initial effort last year and stated every indication pointed to an even more successful effort this fall. Details of the Drive will be announced later.

Other members of the Committee are: George N. Burger, M. D., Covington; Frank H. Moore, M. D., Bowling Green; Herald K. Bailey, M. D., Ashland; Franklin B. Moosnick, M. D., Lexington; Luther Bach, M. D., Lexington; William P. Hall, M. D., Paducah; William R. Parks, M. D., Harlan; and Guinn S. Cost, M. D., Hopkinsville.

Selective Service to Call 355 Physicians in September

Kentucky will be expected to provide eight physicians out of the 355 the Department of Defense is asking for during the month of September, according to information received by the Kentucky Advisory Committee to Selective Service, A. Clayton McCarty, M. D., Louisville, Chairman, reports.

Physicians remaining in the Priority I pool are expected to be absorbed by the first of 1953. The Priority II group will provide the needed number of men, it is estimated, for the first three or four months of the new year.

Physicians in Priority III are now being reclassified by local boards and their pre-induction examinations, to determine their physical fitness, are expected to be ordered at any time.

The order in which Selective Service calls up the physicians as provided for under Public Law 779 is detailed under paragraph 8 of Operations Bulletin No. 75 as follows: "... who are in the first or third order of priority will be selected for induction in order of their dates of birth, the youngest being selected first. Those who are in the second or fourth order of priority shall be selected according to their length of active duty in the Army, Air Force, Navy, Marine Corps, Coast Guard and Public Health Service." Military service prior to entrance in medical school does not apply to men in Priority II.

The State Advisory Committees have been told that the various branches of the Armed Forces expect to discharge approximately 2000 physicians, who had served their allotted amount of time, in the next few months. Of this number, many are veterans of the fighting in Korea.

Of the 355 physicians scheduled for induction in September, 180 will be assigned to the Army and 175 to the Air Force. The September call brings the number of physicians requested by the Department of Defense since July 1951 to 1522.

AMA to Assist in Replacing M.D.'s Called Into Service

Kentucky will receive assistance in the problem of finding replacements for physicians that are being absorbed by the Armed Forces through Selective Service and the Reserve Components from a new service established by the Council on National Emergency Medical Service of the American Medical Association, A. Clayton McCarty, M. D., Louisville, Chairman of the Kentucky Advisory Committee to Selective Service, has announced.

Information on physicians completing their tours of duty with the Armed Service will be collected by C. Joseph Stetler, Secretary of the A.M.A.'s National Emergency Medical Service Council. These men will be classified by states, and the information will include post service plans, qualifications and specialties.

Names of the physicians completing their military service and desiring to locate in Kentucky or continue their training in Kentucky will be forwarded to the Kentucky Advisory

Committee, as possible replacements for Priority I physicians.

This information will also be made available, Mr. Stetler said, to the State Medical Association offices through the physician placement service of the Council on Medical Service of the A.M.A.

Committee Issues Statement On Centennial Volume

The sale of the Memorial Volume of last year's Centennial has proven gratifying. There is some unfinished business to complete before this account can be considered satisfactorily closed. The enterprise is still in debt to the K.S.M.A. in an amount less than \$900.

The clearing of this obligation will be derived from the 84 persons who have ordered 110 copies but who have not yet paid for and received them and from a few more than 100 copies remaining on hand. These remaining copies are available at the K.S.M.A. office at the publication price of \$5.00 each, and those remaining at the time of the annual meeting will be placed on sale there.

Sam A. Overstreet, M. D.,
Chairman, Centennial Committee

Local Student AMA Plans Active Program For New Term

The University of Louisville Chapter of the Student American Medical Association will have both a full and interesting program for the 1952-53 year if present plans of the Chapter Officers materialize, Peter A. Overstreet, President of the Chapter and senior at the Medical School, said.

The local organization, which has a membership of more than 150 students, is one of the charter chapters of the national organization. It is starting its second full year of activity, which promises to be of much value to its members. Other chapter officers are: Robert Brashear, Irvine, Vice-President and Genrose Haselwood, Louisville, Secretary-Treasurer.

In discussing plans for the new school year, which starts September 16, the President of the local chapter took time out to commend Dean Murray L. Kinsman and the Medical School Faculty for all of the efforts that have been made to improve the School. "The Student A.M.A. recognizes the fact that the Dean and the Faculty are continually looking ahead, streamlining administrative procedures and developing a more efficient teaching program.

They are doing everything they can to improve the course of study and to make our school an up-to-date institution," Mr. Overstreet said.

In addition to other benefits derived by members of the Student A.M.A., the national organization issues a publication each month during the school year, which carries authoritative articles on problems of prime interest to medical students and interns.

Medical Schools Receive \$15,000 From Educational Foundation

The National Fund for Medical Education made grants of \$15,000 to each of the seventy-nine medical schools in the United States on July 31, according to Hiram W. Jones, Executive Secretary of the American Medical Education Fund.

The two-year medical schools received \$7,500 each. The total amount distributed approximated \$1,132,500.00, Mr. Jones said.

In the last twelve months, medical schools have received more than \$2,500,000 from the Fund, of which \$1,417,752 came from the Medical Profession. The 1952 goal of the American Medical Education Foundation of \$2,000,000 has been 42.3% realized, as of August 2, as announced by the American Medical Association.

Dr. Harvey Named Chairman of New School Health Committee

Clark Bailey, M. D., Harlan, President of the Association, has announced the appointment of a Committee on School Health, naming Daryl P. Harvey, M. D., Glasgow, as Chairman.

The purpose of the Committee is to study the health of Kentucky's school population and promote methods of improving it. In addition, the Committee will study the working relationships between the teaching and medical professions and work toward a better coordination of the school health effort.

At the July 17 meeting of the Executive Committee in Lexington, Bruce Underwood, M. D., Secretary and General Manager of the Association, recommended that the Committee investigate the possibility of holding a statewide school health conference. The Executive Committee accepted the suggestion and asked the Committee on School Health to explore the matter.

Other members of the Committee on School Health are: H. B. Mack, M. D., Pewee Valley; William J. Temple, M. D., Covington; Carl

Grant, M. D., Winchester; Walter L. O'Nan, M. D., Henderson; D. G. Miller, M. D., Morgantown; Carl Pigman, M. D., Whitesburg; and W. E. Hoy, M. D., Ashland.

Forty Hear Atomic Illness Program At 6th District Session

Approximately forty physicians attended the regular quarterly dinner meeting of the 6th Councilor District at the Glasgow Country Club, August 12, L. O. Toomey, M. D., Councilor, announced.

Clark Bailey, M. D., Harlan, President of the Association, was the featured speaker. The scientific program, which was well received and which provided much interest, covered the various phases of the treatment of Atomic Illness, Dr. Toomey said.

The following presented the scientific program: Henry Harris, M. D., Bowling Green; Major M. Weinberg, M. C., Fort Knox; and Robert M. Coleman, M. D., Hopkinsville. In addition an Army film on this subject was shown.

Fourth District Attracts 65 to Bardstown Session

Sixty-five physicians and their wives attended the annual dinner meeting of the Fourth Councilor District, at which Clark Bailey, M. D., Harlan, President of the Association, was the featured speaker, according to the Councilor, J. I. Greenwell, M. D., New Haven.

In addition to President Bailey and the guest essayists, R. Haynes Barr, M. D., Owensboro, attended the meeting which took place in My Old Kentucky Home Country Club at Bardstown. The Nelson County Medical Society was the host group, and its president, John J. Sonne, M. D., Bardstown, presided.

The scientific program was presented by Winston Rutledge, M. D., Malcolm Thompson, M. D., and Robert Hendon, M. D., all of Louisville. Dr. Greenwell described the meeting as one of the best his district had held.

Governor Lists Appointments

According to a recent announcement from Governor Lawrence W. Wetherby's office, the following members of the Association have been re-appointed to a four year term of office on the Medical Research Commission: Guy Aud, M. D., Louisville; B. B. Baughman, M. D., Frankfort; and C. C. Howard, M. D., Glasgow.

KSMA Committee Meets at Harlan

Members of the Advisory Committee to the United Mine Workers of America Welfare and Retirement Fund were guests of the Harlan County Medical Society in Harlan the evening of August 2, and participated in a discussion of the Committee's activities led by the Chairman, Carl Fortune, M. D., Lexington.

Prior to the dinner meeting, the Committee held a regular meeting that afternoon at the Lewellan Hotel. Guests of the Committee were Clark Bailey, M. D., Harlan, President of the Association, and Sam Flowers, M. D., Middlesboro, Chairman of the Association's Committee on Hospitals. Committee members present, in addition to Chairman Fortune, were: George F. Brockman, M. D., Greenville; Walter Cawood, M. D., Harlan; C. Dana Snyder, M. D., Hazard; and A. G. Osborne, M. D., Pikeville.

S.M.A. Names Dr. McCarty

A. Clayton McCarty, M. D., Louisville, has been appointed a member of the Council of the Southern Medical Association from Kentucky for a regular five year term, Walter C. Jones, M. D., Miami, Florida, President-Elect of the S.M.A., has announced.

Dr. McCarty succeeds Clifford N. Heisel, M. D., Covington, who has served his constitutional limit and is not eligible for reappointment. Dr. McCarty will take office immediately following the Miami meeting this November.

KSMA Lists New Members

The Association welcomes the following new members:

Bourbon—Estill F. Hall, Paris; William Cox, Paris.

Boyle—Julian R. Hardaway, Danville.

Garrard—O. S. Playforth, Lancaster.

Wayne—Robert Breeding, Monticello.

Wives Welcome

The Woman's Auxiliary to the Kentucky State Medical Association welcomes the wives of all doctors to the business and social sessions of the Auxiliary. The Auxiliary also will have a Hospitality Room in the Crown Hotel for the benefit of the wives to meet and get acquainted, Mrs. John Harter, President, has announced.

(Continued from page 398)

will be especially helpful in your own community in case of disaster of any nature, flood, explosion, tornado or extensive fire. In organizing such a program you are not only doing your part as a member of a state or local team but you are preparing your OWN community to take care of itself in ANY emergency or disaster. Such a local team of physicians did excellent work in a train wreck at Erie, Pennsylvania and a team of one physician rendered excellent service on the snowbound streamliner in the Rocky Mountain last year.

It is essential that every General Practitioner in our great commonwealth find himself a place on our State Civilian Defense set-up. He can serve as a member of any of the following teams: Aid Station, Shock, Burn or Surgical. Your Committee on Emergency Medical Service feels quite certain that every available General Practitioner will be willing and eager to serve wherever he is needed, and we urgently request that you take your place in the Civilian Defense effort at once for the need is NOW.

Pertinent Paragraphs

The American Medical Association has delayed action on establishing any new specialty boards involving the certification of persons who are not doctors of medicine until after the Council on Medical Education and Hospitals has completed its study of all allied scientific fields.

"The Heart of America," a new series of radio transcriptions, has been released by the A.M.A.'s Bureau of Health Education. The 13 programs in the series dramatize the various aspects of the heart and its diseases and are summarized by outstanding cardiologists and related experts. Subjects included in this series may be had by writing K.S.M.A. Headquarters Office. The programs were produced in cooperation with the American Heart Association.

The new Joint Commission on Accreditation of Hospitals has opened its office at 660 Rush Street, Chicago, with Edwin L. Crosby, M. D., former superintendent of Johns Hopkins Hospital, Baltimore, as Director. The Commission,

with representatives from the American Hospital Association, the American College of Surgeons, the American College of Physicians, the Canadian Medical Association and the American Medical Association, will assume responsibility for the hospital standardization program formerly carried out by the American College of Surgeons.

The President's Commission on the Health Needs of the Nation has scheduled October 7, 8 and 9, 1952, for hearings on the controversial question of financing medical care. Walter Reuther, UAW-CIO president and chairman of the Commission's panel on financing of medical care, will preside. Representatives of all insurance proposals, including those who have been urging adoption of the Truman-Ewing plan for national compulsory health insurance, will be invited to testify.

The Council on National Emergency Medical Service of the American Medical Association is assisting the Federal Civil Defense Administration in locating Regional Medical Directors. The Council urges any physician interested in applying for this position to contact its Secretary, C. Joseph Stetler, 535 North Dearborn, Chicago.

The Committee on Indigent Care of the AMA's Council on Medical Service has suggested the following points as a standard for developing indigent medical care plans. Indigent medical care plans should provide all the services which normally are available locally to other citizens, and should make equal services available to all indigent persons. Such a plan should provide for medical supervision and, wherever possible, offer a free choice of physicians for both home and office care. The Committee believes that medical care for the indigent is a local problem and requires the cooperation and participation of local physicians.

The Arthritis and Rheumatism Foundation is offering research fellowships in the basic sciences related to arthritis. The predoctoral fellowships will range from \$1,500 to \$3,000 per annum depending on the family responsibilities of the fellow, and the postdoctoral fellowships will range from \$3,000 to \$6,000 on the same basis. The deadline for applications is November 1, 1952. For information and application forms write the Arthritis and Rheumatism Foundation, 23 West 45th Street, New York 36, N. Y.

"Go slow" about flouridating water supplies. is the recommendation of the House Select Committee Investigating the Use of Chemicals in Foods, after completing two years of work in this field. Although flouridation has been approved by the AMA, American Dental Association, U. S. Public Health Service, etc., the Committee contended that there are "too many unanswered questions" and urged further clinical study.

The Van Meter Prize Award and two honorable mentions are again being offered by the American Goiter Association for the best essays submitted concerning original work on problems related to the thyroid gland. The Award will be made at the annual meeting of the Association, Chicago, May 7, 8 and 9, 1953. Further information may be obtained by writing George C. Shivers, M. D., Corresponding Secretary, 100 East Saint Vrain Street, Colorado Springs, Colorado.

A five-year residency in Psychiatry is now being offered by the California Department of Mental Hygiene. The program consists of three years of training and two years of service as a staff psychiatrist and will normally fulfill requirements for the Board certificate. Interested physicians or senior medical students should write to California State Personnel Board, 1015 L Street, Sacramento, California.

The Nashville Medical Assembly (formerly the Nashville Postgraduate Medical Assembly) will hold its Fifth Annual Graduate Session October 29-31, 1952, at the Hermitage Hotel, Nashville, Tennessee. The Assembly is annually sponsored by the Nashville Academy of Medicine and the Davidson County Medical Society. For further information concerning the assembly meeting, write: J. E. Ballentine, Executive Secretary, Nashville Medical Assembly, 647 Doctors Building, Nashville, Tennessee.

The Kentucky Heart Association and the Louisville Heart Association will sponsor and finance a Chair of Heart Research at the University of Louisville Medical School, according to an announcement made by former Governor

Keen Johnson given at the annual meeting of the Kentucky Heart Association in June. Mr. Johnson said that the local and state associations each will contribute \$7,500 annually to provide for a full-time investigator and laboratory assistant at the Medical School and also that this is the first time any affiliate of the American Heart Association has undertaken a project of this nature.

A Temporary Bus Stop has been made through the courtesy of the City Officials and the Louisville Transit Company. North and South bound buses will stop immediately in front of the Auditorium.

"Medical Aspects of Civil Defense," a booklet compiled by the AMA's Council on National Emergency Medical Service, covers the various medical problems involved in civil defense. Included are items on civil defense organization, medical aspects of biologic warfare, chemical defense, atomic burn injury, nature of air raid casualties, mental health and atom bomb injury. Booklets at 25 cents per copy are available on request through the Council.

Designed for lay audiences, a new portable exhibit entitled "Health-1952" will be available by mid-September from the AMA's Bureau of Exhibits for state and county medical societies. The exhibit presents an over-all picture of health conditions in the United States at the present time. The first panel, containing a large, colored modern adaptation of Sir Luke Fildes' painting, "The Doctor," emphasizes improved health conditions in the country today—showing that life expectancy has increased, tuberculosis, diphtheria and pneumonia deaths have skidded to an all-time low, mothers and babies have a much greater chance of surviving today. The second theme shows that Americans require less working time to pay for medical care today as compared with 15 years ago. Finally, the exhibit points out that today there is an easier way to pay for medical care—through voluntary health insurance. The Bureau plans to revise and bring the exhibit up to date each year. The only cost involved to medical societies will be the shipping charges both ways.

County Society Reports

BELL

The regular meeting of the Bell County Medical Society was held June 13, 1952, in the Coca-Cola Room in Middlesboro.

Members present were Drs. C. B. Stacey, Percy Zanger, Fred Weller, Ed Wilson, Sr., R. F. Porter, C. K. Brosheer, S. H. Flowers, C. D. Cawood, and C. S. Scott. Visitors were Drs. Zirkle, Swann and Acker of Knoxville; Dr. Besson of Lynch; Mr. and Mrs. Ed Smith, Misses Pearce, McIntire, Winkler, McIntuff, and Betty Stanley of Pineville.

The minutes of the last meeting were read and approved.

Dr. Wilson, Sr., reported on the purchase of chairs for the new Health Department Building.

Dr. Wilson, Sr., requested that a committee be appointed to write to the State Senators thanking them for their support in the bills passed by the last session pertaining to medical subjects. Dr. Wilson, Sr., and Dr. Fred Weller were appointed to this committee.

The appointment of a Diabetic Committee was made: Dr. Percy Zanger, Chairman, Dr. Adam Stacey and Dr. James Golden.

A letter from the State Society was read pertaining to awards to be given at the next annual session.

The program for the evening was conducted by Dr. William K. Swann, Dr. Joseph Acker, and Dr. Zirkle, the subject being "Surgical Treatment of Mitral Stenosis." The program included movies, slides, didactic review, and presentation of a patient recovered from "Commissurotomy."

C. S. Scott, M. D., Secretary

SCOTT

The Scott County Medical Society met for its regular monthly meeting at the John Graves Ford Memorial Hospital in Georgetown on Thursday, July 3, 1952. The following members were in attendance: Drs. D. E. Clark, Jr., L. F. Heath, A. F. Smith, H. G. Wells, F. W. Wilt, E. C. Barlow, and H. V. Johnson.

The motion was made and seconded that Buford Hall, M. D., be taken as a member of the Scott County Medical Society. Carried.

The motion was made and seconded that emergency services rendered to patients be collected by the Hospital on request of the attending physician. Carried.

The motion was made and seconded that the

Society recommend charts for patients on first floor be kept downstairs. Carried.

The Secretary was instructed to write a note of sympathy to W. S. Allphin, M. D., and hope for his speedy recovery.

H. V. Johnson, M. D., Secretary

UNION

The regular meeting of the Union County Medico-Dental Society was held July 15th, at 7:15 P. M., at Our Lady of Mercy Hospital, Morganfield.

The meeting was called to order by Wm. Humphrey, M. D., President. The minutes of the last meeting were read and approved.

The guest speaker was C. E. Reddick, M. D., Deputy State Health Commissioner, who talked on public health. Dr. Reddick discussed all phases of this subject and pointed out the importance of the functions of public health and the value of good public health education.

Mr. Van Lucas, also a guest, was introduced. He made a few remarks on good relationship with the health department and the practicing physicians.

Members present were Drs. Carr, Conway, Humphrey, Martin, Smith, Stewart, Welker, and Dr. Atherton from Webster County.

A. W. Andreasen, M. D., Secretary

A program to interest general practitioners in industrial medicine recently was launched by the joint committee on education of the American Academy of General Practice and the Council on Industrial Health of the American Medical Association. The project proposes to encourage an understanding of industrial health problems by management and physicians and to develop an education program geared to the GP on both the undergraduate and postgraduate level.

Since more than 90 per cent of American industries employ less than 100 workers, the "family doctor" also must be educated on the part he can play in supervising and directing health and safety programs in small plants without interfering with his regular practice. The AMA's Council is prepared to assist local medical societies in carrying out educational programs designed to bring the employer and physician together by sponsoring local industrial health meetings.

News Items

George S. Allen, Jr., M. D., a graduate of the University of Louisville School of Medicine, class of 1951, has announced the opening of his office at 1402 Central Avenue, Louisville, for the general practice of medicine. Dr. Allen took his internship at the University Medical Center of Ohio State University, Columbus, Ohio.

Marion E. Arnold, M. D., is now in Clinton, where he will do general practice. Dr. Arnold was graduated from the University of Louisville School of Medicine, class of 1951, and received his internship at Louisville General Hospital.

Luther Bach, M. D., has announced the removal of his office from Newport to Lexington and his association with his son, **Lysle M. Bach, M. D.** They will limit their practice to internal medicine, and will occupy the office of the late **Arthur Bach, M. D.**, brother of Doctor Luther. Dr. Lysle graduated from the University of Louisville School of Medicine in 1951. He took his internship at Baptist Hospital, Louisville.

Benjamin M. Drake, M. D., formerly in charge of county health work for the West Virginia State Department of Health, has been made head of Preventive Medical Services, State Department of Health, Louisville. He has been assigned to the post formerly held by **Robert L. Hansen, M. D.**, who has been transferred to Texas.

Phillips Briggs, M. D., a 1951 graduate of the University of Louisville School of Medicine, has announced the opening of offices at 4126 Taylor Boulevard, Louisville, and will do general practice. Dr. Briggs received his internship at SS. Mary and Elizabeth Hospital, Louisville.

Nathan Cantor, M. D., has announced the opening of his office at 203 W. 4th Street, Owensboro, and will limit his practice to Orthopedic Surgery. Dr. Cantor is a 1945 graduate of the University of Maryland School of Medicine and took his internship at Newark City Hospital, Newark, New Jersey. He was associated with the V. A. Hospitals at Perry Point, Maryland, and Louisville and was with Kosair Crippled Children's Hospital, Louisville, from 1949 to July 1952.

Reginald V. Bennett, M. D., has located in Warsaw and will do general practice. Dr. Bennett was graduated from Duke University School of Medicine, class of 1950, and interned at the William Beaumont Hospital, El Paso, Texas.

William Cox, M. D., has located in Paris for the general practice of medicine. Dr. Cox received his M. D. degree from the University of Louisville School of Medicine, class of 1951, and interned at the Good Samaritan Hospital, Lexington.

H. K. Dillard, M. D., formerly of Warsaw, is now located in Louisville, where he is Director of the Division of School Health, for the State Department of Health. Dr. Dillard was graduated from the University of Louisville School of Medicine in 1937.

Frederick C. Ehrman, M. D., a 1941 graduate of the University of Louisville School of Medicine, now has his office in the Francis Building, Louisville, and will limit his practice to neuropsychiatry. Dr. Ehrman received his internship at the U. S. Marine Hospital, Norfolk, Virginia, and took his residency in Neuropsychiatry at the V. A. Hospital, Louisville.

Verne V. Eskridge, M. D., has returned to Owensboro to open an office and will do general practice. Dr. Eskridge was graduated from the University of Louisville School of Medicine in 1951 and served twelve months rotating internship at SS. Mary and Elizabeth Hospital, Louisville.

David Griffin, M. D., who has been associated with the V. A. Hospital, Louisville, is now located in the Heyburn Building and will do surgery. Dr. Griffin is a 1943 graduate of the University of Louisville School of Medicine. He interned at the U. S. Naval Hospital, Portsmouth, Virginia.

Elsie Lewis, M. D., a 1943 graduate of the University of Louisville School of Medicine, has associated with **Malcolm Thompson, M. D.**, Heyburn Building, Louisville, for the practice of surgery. Dr. Lewis interned at Youngstown, Ohio, and had his surgical training at Nichols V. A. Hospital, Louisville.

R. F. Hansen, M. D., formerly Preventive Medicine Chief of the State Department of Health, has been appointed V. D. officer for Texas, New Mexico, Oklahoma, Arkansas and Louisiana for the U. S. Public Health Service. Dallas will be his headquarters.

Elmo K. Hughes, M. D., who was graduated from the University of Louisville School of Medicine in 1951, has opened an office in Pleasure Ridge Park, for the general practice of medicine. Dr. Hughes interned at St. Anthony Hospital, Louisville.

William H. McKenna, M. D., is now located in Mt. Sterling and will do general practice. Dr. McKenna is a 1951 graduate of the University of Louisville School of Medicine and interned at Baptist Hospital, Louisville.

Charles F. Martin, M. D., has announced the opening of offices in the Averitt Building, Winchester, for the general practice of medicine. Dr. Martin is a graduate of the University of Louisville School of Medicine, class of 1951, and was an intern at the Good Samaritan Hospital, Lexington.

Presley F. Martin, M. D., a 1951 graduate of the University of Louisville School of Medicine, has located in Elizabethtown and will do general practice. Dr. Martin interned at St. Anthony Hospital, Louisville.

Herman R. Moore, Jr., M. D., has opened an office in the Heyburn Building, Louisville, and will limit his practice to general surgery. Dr. Moore is a graduate of the University of Louisville School of Medicine, Class of 1944. He took his surgical training at Nichols V. A. Hospital, Louisville.

John M. Moorhatch, M. D., who has completed his internship at St. Joseph Infirmary, Louisville, has announced the opening of his office at 1100½ Burnett Avenue, Louisville, for the general practice of medicine. Dr. Moorhatch was graduated from the University of Louisville School of Medicine in 1951.

O. S. Playforth, M. D., has entered practice in Lancaster where he will do general practice of medicine. Dr. Playforth was graduated from the University of Louisville School of Medicine in 1951 and took his internship at St. Anthony's Hospital, Louisville.

Harold C. Morris, M. D., has become associated with **Foster Coleman, M. D.**, Brown Building, Louisville, and will limit his practice to internal medicine. Dr. Morris was graduated from Northwestern University Medical School, Chicago, class of 1950, and took his internship at Louisville General Hospital. For the last year he has been in Maywood, Illinois.

Lt. Colonel Philip J. Noel, Jr., Louisville, currently stationed in Korea, has been elected president of the X corps Medical and Dental Society, according to an Army news release. Col. Noel recently completed his residency training at the Louisville General Hospital.

Paul Parks, M. D., announces the opening of an office in Richmond, and will do general practice. Dr. Parks, a 1948 graduate of the University of Louisville School of Medicine, was formerly with Nichols Hospital, Louisville. He interned at Louisville General Hospital.

Paul D. Pedersen, M. D., formerly in charge of venereal disease control in Missouri, has become Director of Venereal Disease Control with the State Department of Health, Louisville. Dr. Pedersen received his master's degree in public health from Johns Hopkins University, Baltimore, Maryland.

Kenneth G. Ross, M. D., a 1942 graduate of the University of Tennessee College of Medicine, has located in Murray for the general practice of medicine. Dr. Ross interned at Charity Hospital, New Orleans.

George O. Roth, M. D., has announced the opening of his office in the Brown Building, Louisville, for the practice of internal medicine. Dr. Roth is a graduate of the University of Louisville School of Medicine, class of 1948, and took his residency at St. Joseph Infirmary, Louisville.

James Wygal, M. D., has announced the opening of offices in the Fincastle Building, Louisville, for the practice of psychiatry. Dr. Wygal was graduated from the University of Louisville School of Medicine in 1945. He took his internship at the U. S. Marine Hospital, Norfolk, Virginia, and his residency in psychiatry at the Sheppard and Enoch Pratt Hospital, Towson, Maryland, and the Washington-Baltimore Psychoanalytic Institute.

Sam O. Taylor, M. D., who has recently completed his internship at St. Anthony Hospital, Louisville, has located in Beattyville, and will do general practice. Dr. Taylor was graduated from the University of Louisville School of Medicine in 1951.

Thomas S. Wallace, Jr., M. D., is now located in Mt. Washington for the general practice of medicine. Dr. Wallace received his M. D. degree from the University of Louisville School of Medicine in 1951 and took his internship at St. Joseph Infirmary, Louisville.

Carroll Witten, M. D., a graduate of the University of Louisville School of Medicine, class of 1951, announces the opening of his office at 2235 Taylorsville Road, Louisville, for the general practice of medicine. Dr. Witten interned at St. Joseph Infirmary, Louisville.

L. E. Smith, M. D., has been appointed as a medical Field Director to assist **C. E. Reddick, M. D.**, Louisville, Deputy Commissioner in charge of Local Health Service, in helping county health departments. Dr. Smith was formerly Executive Secretary of the Kentucky T. B. Association.

In Memoriam

CLAUD EVERETT KIDD, M. D.

Paducah

1871 - 1952

Dr. Claud Everett Kidd died Thursday, May 8, at his home in Paducah. He was born in Livingston County and was graduated from the University of Louisville Medical Department in 1907. He specialized in anesthesia and was on the staff of the Illinois Central Hospital until his retirement in 1946.

ARTHUR BACH, M. D.

Lexington

1893 - 1952

Dr. Arthur Bach was born in Breathitt County and attended Berea College and Eastern State Normal School. He was graduated from the University of Louisville Medical Department in 1917 and later did graduate work at Harvard Medical School. He is a member of a family of four doctors.

In 1928 he moved to Lexington where he resided until his death.

EDWARD BROADDUS ATKINSON, M. D.

Cane Valley

1868 - 1952

Dr. Edward Broaddus Atkinson, Adair County, died at his home in Cane Valley on April 25. He had been in declining health for several years.

He was born in Barren County on October 23, 1868 and received his early education in the Barren County Schools and was at one time an engineer and surveyor. He graduated from the Kentucky School of Medicine in 1896. After he completed his medical education he came to Cane Valley where he practiced until his death. He was an old fashioned country doctor and was loved by all who knew him.

GEORGE EAGLE BUSHONG, M. D.

Tompkinsville

1900 - 1952

Dr. George Eagle Bushong, prominent physician of Monroe County, died at 9 A. M., July 26, 1952, after an illness of several months.

Dr. Bushong had practiced medicine in Tompkinsville for twenty-seven years. He was prominent in Republican politics and served as sheriff of Monroe County during the 1940-44 term. He was President of the Kentucky Sheriff's Association during his term of office.

Dr. Bushong was a partner in several local businesses and was an extensive landowner. He was the son of the late Dr. George W. Bushong, who practiced medicine in Tompkinsville for thirty-seven years.

Dr. Bushong served as medical examiner of the Draft Board, No. 123, during World War II. He was graduated from the University of Louisville School of Medicine in 1924, and served his internship at General Hospital, Louisville.

JESSE A. FRANZ, M. D.

Russell

1885 - 1952

Dr. Jesse A. Franz was graduated from the Medical Department, University of Louisville, in 1910, and immediately after his graduation began the practice of medicine in Russell. He served on the School Board at Russell and was Medical Examiner for the Chesapeake & Ohio Railroad.

Dr. Franz died unexpectedly at his home at nearby Russell on July 14, 1952.

HERBERT HOBSON HUNT, M. D.**Mayfield****1872 - 1952**

Dr. Herbert Hobson Hunt, age 79, died at the Mayfield Hospital, May 29, 1952, of complications, following a broken hip. He was the son of the late William Spencer and Sallie Hobson Hunt, and was born at Cerulean Springs, Trigg County, Kentucky, on October 1, 1872.

Dr. Hunt graduated from the Medical Department, Vanderbilt University, in 1896 and practiced medicine in Mayfield for fifty-four years. He was the Secretary of the Graves County Medical Society for thirty-five consecutive years and after his retirement from that office was made honorary secretary for life. He was a charter member of the Lions Club, was a member of the Odd Fellows Lodge and was active in the civic life of the community.

F. MASON TRAVIS, M. D.**Frankfort****1883 - 1952**

Dr. F. Mason Travis was born January 1, 1883, in Lyon County, Kentucky. He was the son of Jasper and Elizabeth Gray Travis. He attended the public schools of Lyon and Crittenden Counties, and was graduated from the University of Louisville Medical Department on May 31, 1907. He entered practice at Gilbertsville, Kentucky, and was engaged in general practice there for six years. In 1913 he was appointed physician of the prison hospital at Eddyville, where he remained until 1917. Dr. Travis then moved to Benton, where he was engaged in private practice until 1925, when he was appointed physician in charge of the hospital at the Kentucky State Reformatory at Frankfort. In 1933 he again devoted his entire time to private practice. He specialized in X-ray work and took postgraduate courses at the Cook County Hospital, Chicago, Illinois, and at the Cleveland City Hospital, Cleveland, Ohio.

Dr. Travis was a member and a Past President of the Franklin County Medical Society, the Fifth District Medical Society, the Frankfort Lions Club, and the Board of Stewards of the First Methodist Church. He was a member of the Kentucky State Medical Association, the American Medical Association, and the Order of the Eastern Star. He was an active member of the Radiological Society of North America, the World Medical Associa-

tion, the Masonic Order, including the Royal Arch, Knights Templar, Scottish Rite, Shrine, and was a member of the Kentucky State Board of Health. He was listed in "Who's Important in Medicine" in 1945 (1st Edition). Dr. Travis served the U. S. Compensation Commission as physician and had a wide experience as physician for various industries.

GEORGE EDWARD HATCHER, M. D.**Cerulean****1883 - 1952**

Dr. George Edward Hatcher, of Cerulean, died from a heart attack at his home Sunday, May 25, 1952.

Dr. Hatcher was born April 20, 1883, in Pekin, Illinois, the son of Henry and Ellen Clauser Hatcher. He received his medical degree at the University of Tennessee, Medical Department, Nashville, in 1905 and located in that city until he went to Cerulean, where he practiced medicine for thirty-eight years.

Dr. Hatcher was President of the Trigg County Medical and the Four County Medical Societies. He was a member of the Trigg County Board of Health for a number of years and, at the time of his death, he was a member of the Trigg County Hospital Board.

LABORN JONES SIGLER, M. D.**Clay****1858 - 1952**

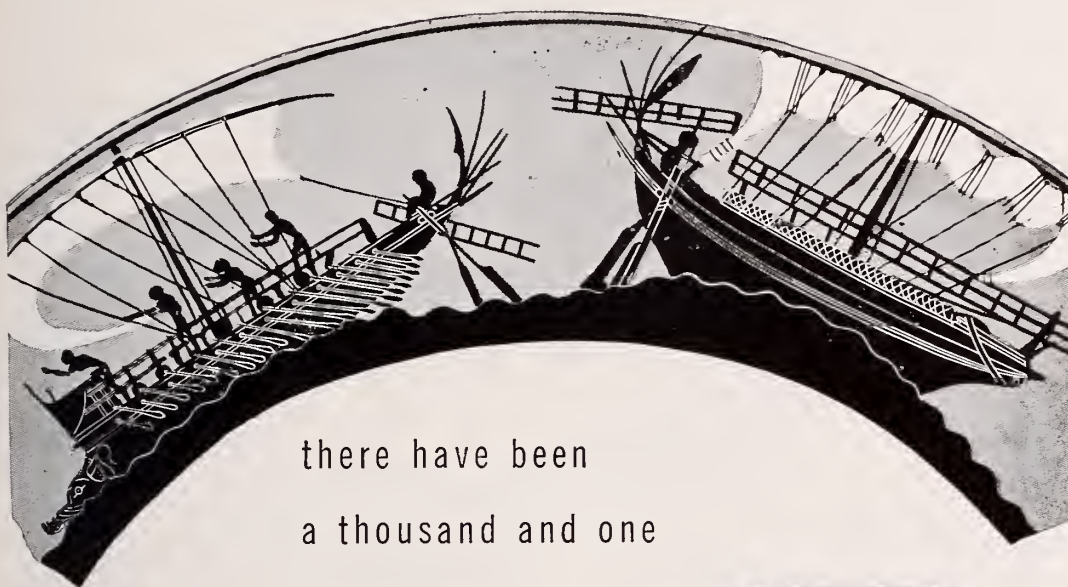
Dr. L. J. Sigler died at his home in Clay June 6, 1952, at the age of 93. He was born on a farm near Clay, the son of Jacob and Elizabeth Sigler.

Dr. Sigler was graduated from the University of Louisville Medical Department in 1893, and immediately after his graduation, he located in Clay where he practiced until a few years before his death.

A. J. WAHLE, M. D.**Somerset****1881 - 1952**

Dr. A. J. Wahle died at his home Thursday, June 26, 1952, at 7 P. M. He came to Somerset in 1911 and practiced his profession here until he retired in 1947. He operated a private hospital until the new City Hospital was thoroughly completed. He was a Surgeon of the Southern Railroad, a Chairman of the Pulaski County Draft Board in World War I, and a mem-

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ber of the Advisory Board in World War II.

Dr. Wahle was graduated from the Medical Department, University of Louisville, in 1908. He was an active member of his County, State and National Associations. His skill and knowledge of medicine were widely recognized and appreciated.

T. H. EGBERT, M. D.

Clinton

1870 - 1952

Dr. Thomas H. Egbert, retired Hickman County physician, died at Clinton May 27, 1952, at the age of 82. After his graduation from the University of Louisville Medical Department in 1898 he returned to Clinton to practice medicine. He also practiced in Missouri for several years before serving in World War I. He returned to Hickman County several years ago and practiced there until ill health forced him to retire after fifty-two years in the medical profession.

E. N. POWELL, M. D.

Corydon

1876 - 1952

Dr. E. N. Powell died at his home in Corydon May 27, 1952, at the age of 76. He was graduated from the University of Louisville Medical Department in 1903, and had practiced medicine in Henderson County from the time of his graduation until his illness stopped him, and ended the era of country doctors in Henderson County. He was a member of the County and State Medical Associations and the American Medical Association. He was a staff member of the Methodist Hospital and had been the county sanatorium doctor for twenty-five years.

ARTHUR GILBERT ELLISTON, M. D.

New Castle

1871 - 1952

Dr. Arthur Gilbert Elliston died at his home in New Castle June 30, 1952, after having practiced medicine for fifty-seven years. Dr. Elliston was a native of Grant County, having practiced there before locating in New Castle. In his early years as a general practitioner he rode horseback over almost impassable roads to visit many of his patients, then he graduated to a buggy, and finally to an automobile. He is widely known for his charity,

particularly among children. Dr. Elliston graduated from the Ohio Medical College in 1894. In 1939 he was appointed to the Staff of Norton Memorial Infirmary in Louisville, and in 1947 was appointed Henry County Health Officer and served until he became ill last March.

D. S. ROBERTS, M. D.

West Point

1871 - 1952

Dr. D. S. Roberts died at his home in West Point on May 18, 1952. He was a native of Meade County and received his education in the Meade County schools and attended the University of Kentucky, graduating in 1893. He taught school in Meade and Breckinridge Counties and moved to West Point in 1901, where he established the first high school. Dr. Roberts then attended the Kentucky School of Medicine, graduating in 1905. Following his graduation from medical school he located in West Point where he practiced until his death.

LYNN DAVID ADAMS, M. D.

Smithland

1880 - 1952

Dr. Lynn David Adams, son of David and Georgia Hunter Adams, was born August 26, 1880 in Livingston County, Kentucky, and died July 11, 1952, of a coronary occlusion.

Dr. Adams was graduated from the Hospital College of Medicine, Louisville, in 1904. He did postgraduate work at Rush Medical School at Chicago, Illinois. He practiced medicine during 1907 in Indian Territory (Oklahoma). Between 1930 and 1943 he was the Medical Director for the State Penitentiary School of Training at Frankfort. The remainder of his professional life was spent at Smithland, in Livingston County.

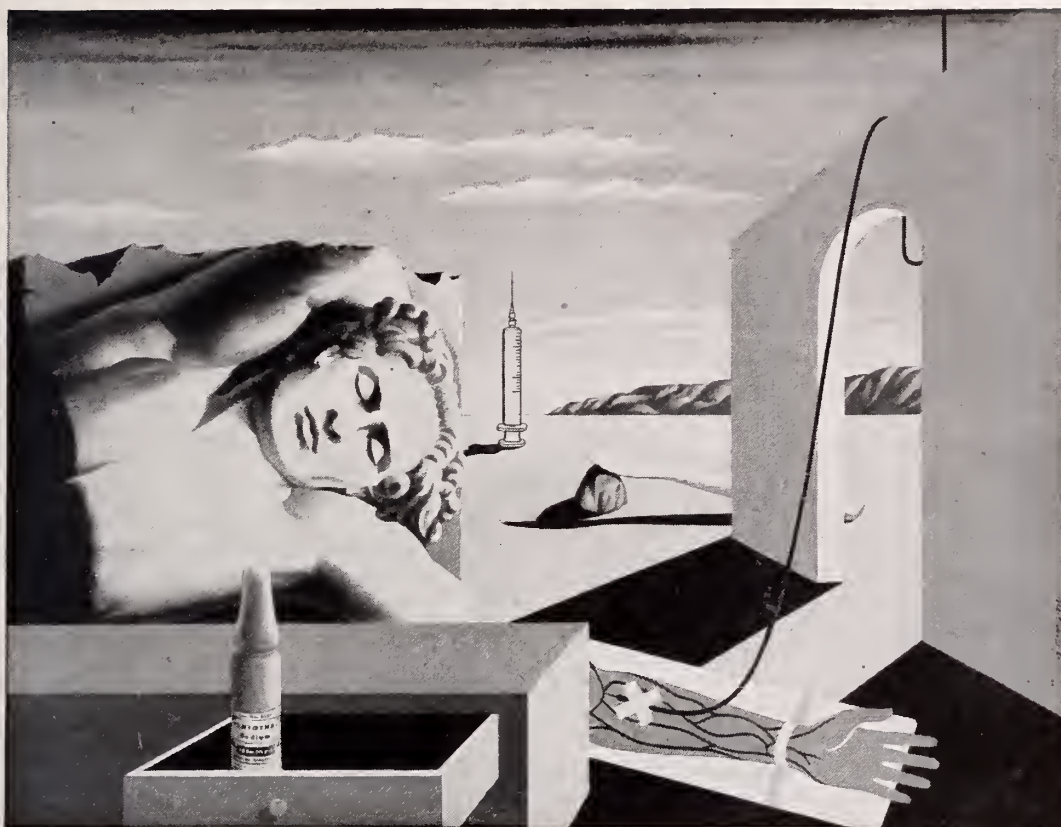
Dr. Adams was a member of the Livingston County Board of Health, and an active member in his county medical society.

TRACY WALLACE, M. D.

Irvine

1879 - 1952

Dr. Tracy Wallace died at his home in Irvine August 16, 1952. He attended the University of Kentucky, and taught school for several years in Estill County. He later attended the Hospital College of Medicine, Louisville, where

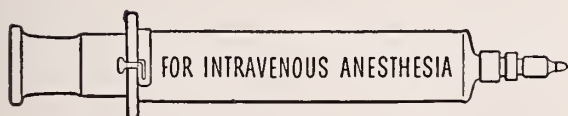


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Adams, R. Charles (1951), Intravenous Administration of Pentothal Sodium in Combination with Other Anesthetic Agents and Methods, J. Missouri Med. Assn., August.

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he was graduated in 1907, since which time he practiced medicine in Irvine until his death. Dr. Wallace was elected Chairman of the Estill County Republican Executive Committee last March and was long active in political affairs.

ARMISTEAD M. LEIGH, M. D.

Louisville

1878 - 1952

Dr. Armistead M. Leigh died at his home in Louisville, August 14, 1952. He was born in Charleston, Mississippi, in 1878, and was graduated from the Hospital College of Medicine, Louisville, in 1905. After his graduation Dr. Leigh returned to his native city where he practiced medicine until 1925. He then came to Louisville where he maintained offices in Crescent Hill and where he practiced medicine until the time of his death.

BOOK REVIEWS

THE FACTS OF LIFE FROM BIRTH TO DEATH By Louis I. Dublin, Ph. D. Second Vice-President and Statistician in Collaboration with Mortimer Spiegelman, F. S. A., Assistant Statistician of the Metropolitan Life Insurance Company. The MacMillan Company, 60 Fifth Ave. New York 11, Publishers. Price \$4.95.

This book is the result of many years of research performed by the statistical staff of the Metropolitan Life Insurance Company under the direction of Dr. Dublin. Hundreds of thousands of inquiries have been received since Metropolitan first became interested in making

public vital information about healthful living. These questions have now been compiled, segregated, tabulated, and worked into a book of organized continuity and lasting value.

It is a convenient and useful reference book that will be welcomed by public health officials, doctors and members of other professions.

PHYSICAL DIAGNOSIS by Harry Walker, M. D., F. A. C. P., Professor of Clinical Medicine, Medical College of Virginia, Richmond, Virginia. 461 pages, 126 illustrations. The C. V. Mosby Company, 3207 Washington Building, St. Louis 3, Missouri. Price \$8.00.

Six outstanding specialists have collaborated in sections on their respective fields, but all of the material has been carefully edited and well correlated by the author.

The inclusion of these various sections by specialists gives it complete coverage and relieves it of autonomous opinion. It is an important and effective book which should certainly earn the respect of its readers.

MEDICAL BIOGRAPHIES—The Ailments of Thirty-three Famous Persons By Philip Marshall Dale, M. D., Los Angeles, California. University of Oklahoma Press, Norman, Oklahoma, Publishers. Price \$4.00.

This volume combines an interesting biography with the fatal illnesses of many famous people, as Henry VIII, Gibbon, Charlemagne and others. It illuminates the dark corners of history by adding to the contributing cause of death the effect of the fatal diseases upon the lives of these men. It is an intensely interesting approach to a rather unusable subject.

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Not In The Thing Itself

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In the current search for remedial agents in cancer, three principal lines of endeavor are being followed.

Study of carcinogens. Attention is being given to substances capable of producing neoplastic growth when administered to experimental animals. The hope of deriving from such studies a knowledge of the processes of cancer production, with the implied corollary development of an agent to counteract such processes, has not been fulfilled.

Study of potential curative agents. There are laboratories in which thoroughly systematized studies of the potential cancer-curative properties of a great collection of miscellaneous agents are being prosecuted in the hope that one may be found to be effective against experimental neoplasms. Such work is by no means to be lightly viewed, because it is actual fact that numerous drugs of value in other maladies have been accidentally discovered. Perhaps planned "accidents" of this sort may turn up for us the cancer-curative drug we want, but so far it has not done so.

Study of the metabolism of cancer cells. The success achieved with chemotherapeutic and antibiotic agents in the infectious diseases in recent years has stimulated investigation of the metabolism of cancer cells as possibly holding the key to the situation. The argument is the following: (a) we are conquering the in-

fectious diseases with drugs that interfere with the peculiar metabolism of the causative organisms without disturbing the tissue metabolism of the human host; (b) hence it follows that if we can elucidate the nature of the peculiar metabolism of cancer cells we will likely be able to devise compounds to interfere with these processes without at all affecting the normal cellular metabolism of the patient's body. Unfortunately, nothing so far of practical import has come of this approach because it has not been possible convincingly to show that the cancer cell has a distinctive metabolism that sets it apart from the normal cell.

The few ameliorative drugs we have are of very limited usefulness. It will take but a few moments to run through this list.

Estrogens. In carcinoma of the prostate, and in some instances of carcinoma of the breast in elderly women, a considerable amelioration of symptoms can be achieved by administration of estrogens. But the effect is only temporary and the patient dies of cancer.

Testosterone. This drug is ameliorative in selected cases of carcinoma of the breast, particularly in instances of metastatic lesions in women under the menopausal age. But the effect is only temporary and the patient dies of cancer.

Nitrogen mustard. In a fair proportion of cases of Hodgkin's disease and mycosis fungoides, and in perhaps three-fourths of the cases of bronchogenic carcinoma in which it is tried, nitrogen mustard re-

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lieves the symptoms and induces some regression of the lesions. But the effect is only temporary and the patient dies of cancer.

Urethane. Sometimes in cases of multiple myeloma, urethane is strikingly beneficial in all aspects of the disease, and in mycosis fungoides and the chronic leukemias similar results are at times achieved. But the effects are only temporary and the patient dies of cancer.

ACTH. This was the bright new hope. The lymphomas have responded and particularly acute leukemia. But the effect is only temporary and the patient dies of cancer.

Aminopterin. This drug is the prototype of a series of compounds found in vitro to combat the growth-promoting action of folic acid. Remission is obtained with aminopterin in about a third of the leukemias in which it is tried. But the effect is only temporary and the patient dies of cancer.

Stilbamidine and neostibosan. In multiple myeloma there is an elevated serum globulin. This finding occurs also in kala-azar. It was therefore logical to employ the specific agents of kala-azar—stilbamidine and neostibosan—in this malignancy. In a disputed proportion of cases the symptoms are alleviated and specific alterations are effected in the cytoplasm of the myeloma cells. But the effect is only temporary and the patient dies of cancer.

This is a catalogue of failures, but why? I should like to suggest that the answer to this question may possibly be found in a statement made by Francis Bacon considerably more than 300 years ago, a sentence occurring in the preface to his "Novum Organum," published in London in 1620¹. Here is the sentence: "No man can rightly and successfully investigate the nature of anything in the thing itself." I submit that the neoplastic growth, the tumor, the cancer is an end product; that it is "the thing itself," and that not in a study of the thing itself will we find the answer to the enigma of its causation or the clue to its prevention or cure. I shall attempt to support this viewpoint in what follows.

Cancer is not repugnant to the body. Though we may diagnose cancer with sad dismay and regard the lesion with repugnance, the body does not at all share this attitude. On the contrary, it neither attempts to rid itself of the new growth nor

shuns the responsibility for its support². An infectious process, or a foreign body, or a bit of dead tissue not removable by phagocytosis (a sequestrum of bone, for example), is quickly walled off, but cancer is not so treated. The cancerous growth is actually supplied with blood vessels of the body's own manufacture, and the effort is always made, though ultimately it may fail, to keep the growing tumor fully supplied with blood. Work, too, extra work is done for it, which may be demonstrated experimentally in both spontaneous and transplanted tumors in rats³. In these animals there occurs an hypertrophy of both heart and liver in reasonable proportion to the increase in the size of the neoplasm. And finally, the tumor may actually function and contribute physiologically to the body economy, though admittedly this is often above the requirements of the economy as a whole. Adrenal pheochromocytoma and tumors of the islets of Langerhans in the pancreas, with their respective contributions of epinephrine and insulin, are examples here. Definitely, cancer is not repugnant to the body.

Cancer is a normal response to an altered environment. The proposition seems inescapable that the body behaves toward malignant tissue precisely as toward any other tissue with a high metabolic rate: it supports it at the expense of less demanding tissues. The situation is not without analogy to that of a family into which a mongolian idiot has been born. Neoplasm, like the mongoloid, is a "normal" body response to an altered environment, and the attempt is made in both instances to "assimilate" the new type of tissue—in the case of the neoplasm it is an attempt on the part of the body to take care of this monstrous product of its own manufacture, in the case of the mongoloid the attempt is made by the family. In both instances the product of an altered environment is supported at least to the extent of not obstructing its development. Neoplasms, like other tissues, are the products of their environment. One does not have to assume that the cells involved in neoplastic growth were congenitally constitutionally anomalous but only that the environment which fostered their development was altered.

The pre-metastatic phase is ideal for investigation. The surgeon, given opportunity to diagnose in a still operable stage, can often relieve the cancer patient of his

primary tumor and restore him to apparent health. But it is an indication of his fundamental failure, and one of the greater tragedies of our period, that the surgeon is obliged to use the "five-year-survival" yardstick to measure his achievement. He removes the initial lesion and then both he and the patient begin to wait for another to form. As long ago as 1905, Albrecht⁴ said of tumor formation that it is a repetition of an organ-forming process. Like organs, too, tumors continue to develop typically, apparently after the altered environment which gave rise to them has reverted to the normal. This is like an arsonist running away from the fire he has kindled, leaving it to rage and destroy. But the arsonist often comes back, and that is the time to catch him. So too, the cause of cancer returns. But this return, which provokes the metastatic lesions, may be deferred for several years, and during that time, as good detectives,

we should be busy. There is no need to seek pre-cancerous factors here, for it is known that this patient is cancerous. Indeed, in the pre-metastatic patient alone do we really have a disease to investigate, for we know that in this person there are cells, dispersed usually in certain typical sites, capable of unbridled neoplastic multiplication. This multiplication may or may not take place. We must discover what alterations in environmental circumstances cause the new growth to begin. The new growth, the tumor, is unimportant, for the answer to the enigma of its causation is not to be found in the thing itself.

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The Celiac Syndrome

Treatment With Diet And Liver Extract

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The celiac syndrome has been recognized since Gee's classical description in 1888 of patients with a chronic digestive disturbance showing characteristic wasting of the muscles and subcutaneous fat, prominent abdomen and copious mushy gray foul-smelling stools containing abnormal amounts of fat. Interest in the condition in this country began with the publication in 1908 of Herter's monograph on infantilism from chronic intestinal infection, (1). Increasing numbers of such patients were discovered after attention was directed to the existence of the syndrome. For many years it was known as chronic intestinal indigestion or celiac disease and considered as a disease entity. By 1935, however, clinical observations of the difference in response to the generally accepted treatment with low-fat high protein diets, together with the presence of troublesome cough and pulmonary infections in some celiacs, had led to the clinical and pathological studies of Parmelee (2), Anderson (3), Blackfan and

May (4), and Rauch, Litvak and Steiner (5), in which it was demonstrated that a group of patients with cystic fibrosis of the pancreas differed radically from the others. Thaysen (6) also pointed out the difference between non-tropical sprue, which he considered analagous to Gee-Herter's Disease in adults, and what he refers to as pancreatogenous steatorrhoea.

The diagnostic problem is usually the differentiation between cystic fibrosis of the pancreas and idiopathic celiac syndrome. Both have in common a steatorrhoea, enlargement of the abdomen and wasting, but these manifestations arise from different underlying causes in the two diseases, namely a defective absorption by the intestinal mucous membrane in the idiopathic celiac syndrome and an absence or diminution of pancreatic ferments in cystic fibrosis. Andersen (7) and Schwachman (8), agree that trypsin determinations on carefully collected specimens of fluid from the middle third of the duodenum represent the best available index of pancreatic enzyme activity. They found a complete absence of trypsin in cystic fibrosis. In the idiopathic celiac

syndrome trypsin can be demonstrated and its presence in any substantial quantity may be considered to rule out cystic fibrosis. A further manifestation of diminished pancreatic ferments is an increased nitrogen output in the stools, which Darrow (9) and Shohl, May and Schwachman (10) and Thaysen (6) have used as a differential point. In addition to these laboratory procedures, there is of course much help to be obtained from the fact that cystic fibrosis is a disease of the respiratory tract as well as the pancreas and the chronic cough and pulmonary infection may be an outstanding characteristic of that disease.

The manifestations of the celiac syndrome may all be traced to the effects of defective absorption of fat and possibly starch. The increased stool fat or steatorrhoea is simply unabsorbed fat. The wasting is to be expected as the result of insufficient absorption of food. The enlargement of the abdomen results from hypotonia of the abdominal and intestinal walls with retention of large amounts of gas and fluid in the intestine. Another important factor is the disturbance in intestinal motility which is also a part of the syndrome and gives rise to the x-ray findings of "clumping" of the barium seen on gastrointestinal studies. The osteoporosis, secondary anemia and occasional vitamin deficiency seen in severe cases are results of the poor nutrition of the patient. Because of the slow rate of growth rickets is minimal or non-existent.

While the so-called idiopathic syndrome and cases of cystic fibrosis account for most instances of the celiac syndrome, in going through the ten year records six cases were found in which there appeared to be an anatomical basis, 2 having hepatosplenomegaly and later developing a syndrome resembling Banti's disease, one apparently the result of congenital atresia with resection and anastomosis, one regional ileitis, one following a hepatitis and one having pancreatic involvement of undetermined nature. These and the cases of cystic fibrosis are not included in the present study, in which we will present only cases of the celiac syndrome for which no anatomical basis may be demonstrated and of which the etiology is unknown. Thirty-seven such patients were seen in the Grace-New Haven Community Hospital in the ten years 1941-50. These 25 female and 12 male children form the basis of our presentation. Tabulation of

age of onset indicates that 8 had their onset under 4 months, 8 from 4 to 6 months, 19 between 7 and 12 months, with the other 2 beginning after 12 months. The onset is more or less insidious and difficult to place accurately but there is a statement in 18 histories that the patient was apparently normal before the onset, while in the other 19 there is a story of diarrhoea or colic or other feeding disturbance since birth or early infancy. We were unable from these data to establish any relationship between this fact and the severity or duration of the syndrome.

The two or three symptoms mentioned in the complaint on admission have been tabulated and we find mention of the stools 25 times, diarrhoea in 9 instances and bulky or foul stools 16 times. Further questioning brought out a history of abnormal stools in some of the others. These figures represent the symptoms which made an impression on the mothers. It is a little surprising that the stools did not make more impression on the parents. Vomiting has not been thought of as such an important part of the celiac syndrome but we have it occurring as a prominent symptom in 17 of 37 cases. Enlargement of the abdomen is gradual and does not impress the mother until quite well advanced. Although our records show abdominal distention was present in practically all cases, the mothers had only mentioned it in 15. Enlargement of the abdomen, foul bulky stools and wasting are the three features usually most frequently associated with the celiac syndrome.

Fifteen mentioned weight loss or failure to gain but further questioning elicited a history of weight loss in every case. This is borne out by the fact that in every case except five the weight of the patient on admission was well below the minimal standard for his age on the graph used in the Children's Medical Center in Boston. These five were all in the lower range of normal and all had histories of loss of weight.

These children are notoriously irritable unless they are prostrated and listless. In the body of the history we find mention of irritability 16 times but from hospital and other experience we know it was more common. I mention this point because its subsidence is one of the first evidences of improvement and is used in the paper in an attempt to evaluate results of treatment.

The duration of symptoms before admission to New Haven Hospital varied from 1 to 7 months in 27 patients. The others had been seen elsewhere and had histories of varying lengths.

Stool studies were done on all the 37 patients. The infants were fed a mixture of whole or half-skimmed milk with added Dextri-Maltose and stools were collected from the diapers or bed-pans for at least 3 days with carmine markers at beginning and end of the study period. In only a few instances were urine and stools collected separately but this does not appear serious if the stools are not liquid. Total fat was extracted from aliquots with alcohol and ether and re-extracted with petroleum ether. The fat was weighed after evaporation of the petroleum ether. With a few exceptions the daily output of fat exceeded 4.0 grams, the highest being an output of 15 grams per day. The figure of 4.0 grams output per day was chosen as being over twice the upper normal range which Andersen (11) found to be 1.79 grams per day. The four lowest ones were known celiacs who had been on a celiac regime, which Andersen (12) states may be expected to abolish the steatorrhoea in about two months. Two others were 3.3 and 3.4, below our standard of 4.0 but in both cases the total amount of stool recovered was small and the patients otherwise resembled the celiac syndrome.

Nitrogen excretion was also measured by the Kjeldahl method and found to be less than 1 gram per day in 31 cases. One was not done. Shohl, May and Schwachman (10) found an output of 1.70 grams per day in a patient with cystic fibrosis against an average of 0.39 gm per day for normals. Of the five who had outputs above 1 gram, 3 had normal trypsin determinations on duodenal aspiration. The two highest values, 1.6 gram and 2.17 gram, may indicate contamination of the stool specimen with urine as they were on patients whose subsequent course indicated that they did not have cystic fibrosis.

Duodenal aspirations were done on 17 of the 37 patients and trypsin was found in all of those done. The determinations were done by the gelatin liquefaction method recommended by Andersen (13). While there is a fairly good correlation between this method and the Farber test which involves digestion of the gelatin on an x-ray plate by a sample of stool, An-

dersen feels that the duodenal aspiration is a more direct and reliable method.

Gastro-intestinal x-rays were made on 23 of the 37 patients with 17 showing the abnormal small bowel pattern or "clumping" of barium characteristic of a "deficiency state" or celiac syndrome. This finding is corroborative rather than pathognomonic as it occurs in other conditions. It is brought about by a disturbance in intestinal motility which may or may not accompany the defective absorption characteristic of the celiac syndrome.

Since the celiac syndrome is characterized by defective absorption leading to undernutrition, it is not surprising that other nutritional disturbances may be super-imposed upon it. One of the hazards of the condition is an acute diarrhoea and three of the present series (J. B., D. K., and E. Z.) were admitted to the hospital with severe dehydration and marasmus resulting from an acute exacerbation of a recurrent diarrhoea. It was only after their water and chemical balances were restored and they were convalescent that the character of their stools and slow convalescence led to the diagnosis of celiac disease. Their histories indicated durations of 1, 12 and 22 months before admission to the hospital. In the last patient (E. Z.) progress was slow and there was definite retardation of growth. Her home situation was bad and she was readmitted at 8 years of age with melena and purpura on a basis of nutritional deficiency. This was relieved by intensive vitamin therapy but she convalesced slowly and had not begun to gain weight on leaving the hospital. We have no further follow-up.

Two other patients (K. K. and M. N.) with histories of symptoms for 15 and 30 months were admitted with tetany and osteoporosis and nutritional edema in an extreme state of emaciation. They are described in charts I and II. Another child (M. M.) with symptoms for 11 months was admitted with nutritional edema and had a positive cephalin flocculation test and serum proteins of less than 4 grams per cent. H. J. had a history of nutritional edema intermittently for 3 weeks before admission. She had a history of 15 months illness including severe diarrhoea and dehydration seen at another institution. Another child (H. S.) had mild tetany on admission with an x-ray diagnosis of osteoporosis. None of those showing osteoporosis with tetany

had x-ray changes indicating rickets.

The only definite manifestation of vitamin A deficiency noted was an instance of xerophthalmia (M. P.) resulting in a residual corneal opacity. This patient was allergic to cow's milk and had been on a soy bean preparation since an early age. One patient (E. N.) was admitted with scurvy and discovered to have the celiac syndrome after admission. Two patients (W. C. and S. M.) had emotional disturbances which seemed to have a definite influence on their symptoms. One had a recurrence of bulky foul stools for two or three days after temper tantrums for about three years after he appeared to have otherwise recovered.

To summarize the above, in the 37 cases there appeared 3 instances of severe diarrhoea and dehydration, 4 instances of nutritional edema, 2 of them having tetany and osteoporosis in addition, 1 child with mild tetany and osteoporosis, 1 case of scurvy, 1 case of xerophthalmia and 2 in whom emotional disturbances played a role, making a total of 12 of the 37 patients showing secondary complications.

The treatment of patients with the celiac syndrome is directed primarily toward maintaining and improving their nutrition in the presence of defective intestinal absorption. There is a reasonable expectation that if this is done the defect will disappear in time and the patient will be able to lead a normal life. In our previous description we have mentioned only the defective fat absorption but in planning a treatment consideration must also be given to carbohydrate intolerance. Carbohydrate intake and output cannot be accurately measured, as can fat and nitrogen, but clinical observations have amply confirmed the role of carbohydrate intolerance, particularly starch. Lowe and May (14) have recently done metabolic studies on patients with starch intolerance in which they found not only a disturbance of electrolyte metabolism but defective fat absorption during the period in which starch was consumed. Sheldon (15), by feeding celiacs on moderately high-fat diets with and without starch, showed that there was a definite improvement in fat absorption as well as a better gain in weight and less irritability when starch was omitted from the diet.

The later clinical laboratory studies have confirmed the rationale of earlier workers who have treated the disease suc-

cessfully since 1921 with a high protein diet low in fat and starch.

Howland (16) in 1921 recommended his three-stage treatment with protein milk as the first stage and Haas (17) introduced the use of bananas in 1924. First used in an attempt to stimulate the appetite, he found them not only well tolerated but beneficial. The addition of banana was particularly fortunate in introducing vitamins A B and C into a regime that was border-line if not actually deficient in these vitamins. Before the development of water-miscible multiple vitamin mixtures the administration of vitamins A and D was particularly inefficient because of their poor absorption when administered in fish oil. May and Lowe (18), Kramer, Sobel and Gottfried (19), and Lewis, Bodansky, Birmingham and Cohan (20) have shown that when administered in the water-miscible form vitamin A is well absorbed by patients with the celiac syndrome. On the basis of these findings the patients reported in this series were all started on the same regime.

Their initial diet was:

half-skimmed milk (2% fat)

cottage cheese

ripe bananas

water miscible multiple vitamin mixture

elixir of ferrous sulfate.

This diet meets all the well-recognized nutritional requirements and patients may be maintained and made to grow and gain on it for extended periods. Half-skimmed milk was usually used instead of skimmed milk because of its greater palatability and it was usually well tolerated. The diet is surprisingly well taken as most children like milk and bananas, its principal ingredients.

There may, however, be unrecognized factors which are not being entirely supplied by such a regime. Over 25 years ago Dr. Lafayette Mendel told Dr. Grover Powers that there were doubtless many vitamins which had not been identified and if one wanted to treat an unknown deficiency with unknown substances, liver extract was most likely to contain the hitherto unrecognized factor. On this basis Dr. Powers (21) instituted the practice of administering liver extract to pre-matures and all patients presenting nutritional disturbances, which included those with the celiac syndrome. Somewhat

later, in 1935, Castle (22) and his co-workers showed that the fatty diarrhoea of sprue, a disease in many ways resembling the celiac syndrome, was promptly relieved by injections of liver extract. There was a definite impression that the response of the celiac syndrome to the dietary regime was enhanced by its use. Therefore, in addition to the above diet, the patients were given injections of crude liver extract (2 units) two or three times a week for from three to six weeks followed by a more or less extended period of weekly injections.

As the patients progress, showing loss of irritability, gain in weight, change in character of stools and lessening of distention, additions are made to the basic diet in the following order:

lean meat

fruits

vegetables

some sugar

starch—later and carefully

fat—last to be added.

These additions should be made very circumspectly and we have tried to remain on the side of slow rather than rapid additions to the diet, the entire period of dietary restriction seldom being less than a year.

With the exception of liver extract injections this is the type of regime generally accepted and used. We have had no experience with the use of emulsifying agents which may enable patients with the celiac syndrome to absorb fat (23), or with feeding large amounts of fat to increase the amount absorbed as suggested by Chung and his co-workers (24). Pancreatin has not been used as it does not seem rational in the presence of trypsin in the fluid from duodenal aspiration.

We have attempted to evaluate the results of this regime by studying the clinical courses of the patients presented. In chart I appears an estimate of the time required for the initial response, which occurred during their hospitalization. The first response noted is a decrease in irritability often accompanied by an improved appetite, with weight gain following after an interval. The hospital records indicated that irritability subsided in 1 week or less in 9 cases, in from 1 to 2 weeks in 10 cases, 2 to 3 weeks in 6 cases, over 3 weeks in 2 cases, no improvement in 1, not irritable in 1 and uncertain in 8. Beginning weight gain was a little later, 2

weeks or less in 16 cases, 2 to 3 weeks in 9, 3 to 4 weeks in 2, over 4 weeks in 1, no gain in 1 and in 3 the hospital stay was too short for estimates to be made. Those with complications required about the same average time for a beginning response as the group as a whole. These figures indicate that a beginning response to treatment may be expected in from one to three weeks after starting the celiac regime.

Of the 37 patients whose hospitalization is summarized in table I, we were able to obtain follow-up information on 24. Table II is based on response to a questionnaire with some clinic visits for re-examination. One patient (H.J.) abandoned the regime on discharge from Grace-New Haven Community Hospital and was admitted 3 months later to another hospital with diarrhoea and dehydration requiring transfusions and much supportive therapy before becoming regulated again. She is apparently being successfully maintained at present on a full diet with the use of polyoxyethelene sorbitan mono-oleate (23). Her name is included in the table but her course cannot be accurately tabulated nor is it possible to evaluate the regime from her course. Of the other 23 we have information at intervals of from 20 to 108 months after discharge. One of the patients (K. Y.) presented is still under treatment 14 months after discharge. His course is summarized in chart III, to be shown later. The ages of the patients at the time of the last follow-up vary from 33 months to 14 years.

Other columns of table II showing the number of months of liver injections, dietary restrictions, time required for definite improvement and duration of abnormal stools and abdominal distention, show very clearly the prolonged tedious course of the treatment.

Liver injections were given to 22 of the 23 patients included in the follow-up and it may be stated that the one not receiving it had one of the longest courses. Five of the patients with milder cases had them for 2 months or less, 3 for 3 months, 5 for from 3½ to 6 months, and 4 for from 7 months to a year. The 5 remaining were given more prolonged courses of from 18 to 41 months, the interval between injections being gradually prolonged in the later stages. The injections were usually stopped if the patient was contented and progressing well as to weight and stools. On several occasions injections were stopped for a period but resumed with re-

Table I
Summary of Hospital Records

Record Number	Initial	Sex	Age of Onset Mos.	Age on Admission Mos.	Weight on admission lb. oz.	Presenting Symptoms	Stools		Trypsin Xray	Response to treatment		Complications
							Fat per day gms.	N per day gms.		G I Irritability	Less Gain in wt. Weeks	
C30252	J.D.	M	<1	15	19-6	Stools Vomiting Abdomen	4.8	0.5	0	0	1	
C22253	A.G.	F	8	14	17-10	Vomiting Abdomen	4.1	0.42	+	+	?	
C25403	M.M.	F	11	13	15-5	Vomiting No gain stools	10.1	0.67	+	+	1 1/2	Nutritional Edema - Pos.Ceph.Flocc.
C26600	G.A.	F	8	12	14-0	Diarrhoea wt. loss	7.6	1.09	+	0	1 1/2	
C35674	B.N.	F	2 1/2	8	11-10	Vomiting Cough Abdomen	2.3	0.70	+	+	1 1/2	
B36710	T.P.	M	11	18	15-14	Stools Weight Loss	9.6	2.17	0	0	-	
B58692	J.B.	F	5	6	10-8	Diarrhoea	3.3	0.23	+	0	?	Severe dehydration
B71431	R.V.	M	10	23	18-2	Kozema Stools Abdomen	7.6	0.73	0	+	1	
B62237	I.F.	F	2	6	9-0	Diarrhoea	3.4	0.23	0	0	3/4	
B95781	Var.	M	7	8	15-14	No gain Abdomen Stools	7.5	0.75	0	-	?	
B95691	L.W.	F	1	8	14-7	Anorexia Diarrhoea Abdomen	2.8	0.47	0	-	-	Old Celliac - Under Control
B95464	J.V.	M	12	26	27-11	Stools Abdomen	2.3	0.67	0	-	-	
B95985	E.C.	F	9	12	18-4	Vomiting stools - Irritable	6.5	0.60	0	-	3 1/2	Severe dehydration, Marasmus
C3761	D.K.	F	12	15	16-15	Stools Fever Anorexia	6.4	0.50	0	+	3/4	Nutritional Edema-Tetany-Osteoporosis
C1302	M.N.	F	6	36	19-10	Stools Weight Loss	13.1	1.17	+	+	1	Scurvy
B68195	E.N.	F	7	8	11-13	Diarrhoea	5.1	0.57	+	0	3	
B79423	A.M.	F	9	21	20-0	Vomiting Anorexia Wt. Loss	5.8	0.50	0	-	<1	
B86693	T.B.	M	70	70	30-3	Abdomen Vomiting Listless	5.5	0.90	0	-	?	Emotional Disturbance
B80590	S.M.	F	20	23	18-15	Diarrhoea No gain Listless	5.5	0.57	0	+	?	Severe dehydration
B7840	E.Z.	F	8	29	23-9	Anorexia Irritable Abdomen	6.6	0.28	0	+	?	Nutritional Edema-Tetany-Osteoporosis
C14966	K.K.	M	11	26	17-14	Wt. Loss Stools Abdomen	10.6	0.71	+	+	1	
C8590	H.J.	F	6	19	18-6	Diarrhoea Vomiting Abdomen	15.1	1.13	+	+	2	Nutritional Edema
C4807	A.T.	F	9	13	18-1	Anorexia Stools Vomiting Abdomen 70% Fat -	5.3	0.43	+	+	3	
C5341	F.K.	F	8 1/2	12	18-8	Vomiting Anorexia Wt. Loss	13.4	0.83	+	0	2	
022490	K.Y.	M	3	19	24-4	Crying diarrhoea pallor	4.5	0.80	0	0	?	1 1/2
B54417	M.G.	F	1 1/2	2	5-15	Diarrhoea Irritable	9.3	0.87	+	+	No imp.	
B30544	A.B.	F	12	15	18-14	Slow gain stools Abdomen	12.8	0.87	+	0	?	Emotional Disturbance
B48598	W.C.	M	6	11	14-8	Vomiting Wt. Loss Stools	4.6	0.22	+	+	?	Xerophthalmia
B47650	M.P.	M	3	4	10-5	Vomiting Cough	10.0	0.70	+	+	?	
B38071	T.S.	M	6	10	14-7	Vomiting No gain Abdomen	8.2	0.77	0	+	?	
A73105	S.B.	F	9	12	15-5	Vomiting Stools Wt. Loss	13.8	0.93	0	+	?	
B30961	C.B.	F	5	7	13-13	Vomiting stools	7.4	0.51	0	+	?	
B13755	D.O.	F	5	9	16-0	Vomiting Stools Wt. Loss	4.6	0.61	0	-	3/4	1 1/2
B33978	R.L.	F	1	5	14-4	Diarrhoea Abdomen	14.3	1.61	0	0	1 1/2	Tetany-Osteoporosis
B33702	H.S.	F	5	11	11-14	Vomiting Wt. Loss	10.5	0.53	+	0	0	
B37103	J.R.	M	1 1/2	5	11-0	Crying Diarrhoea hungry	9.2	0.60	+	0	?	1 1/2
B40959	J.L.	F	6	22	21-1	URI Abdomen Vomiting						

[Key: Under symptoms, the word "stools" indicates their colic character; "abdomen" indicates unusual prominence. Under Trypsin, the plus sign indicates normal content and the "0" that no test was made. Under "G I Xray", the plus sign indicates an abnormal small bowel pattern, the minus sign indicates a normal pattern, and the "0", no examination. Under Response, the minus sign indicates a short stay in the hospital.]

Table II

Summary of Follow-up Information

Initial	Age on Adm. No.	Age at Follow up-yrs.	Interval in Months	Weight lbs.	Height in.	Physique Channel	Nearest Percentile Auxodrome	General Health	Diet Restricted No. Mos.	Liver Injections No. Mos.	Definite Improvement No. Mos.	Stools Abnormal No. Mos.	Abdomen Prominent No. Mos.
J.D.	15	3 1/12	22	32	35 1/2	M	50	Excellent	12	3 1/2	Before Adm.	6	23 +
G.A.	12	3	24	38			67	Good	12	3	2	4	4
Var.	8	4 9/12	49	43	42	A2	15	Good	49	6	2	5	41 +
L.W.	8	4 11/12	51	37	40 1/2	A1	67	Good	4	2	16	16	16
J.V.	26	5 5/12	39	41	43	A1	67	Fair to good	18	10	4	15	39 +
* D.N.	15	4 10/12	43	48	44	A3	2	Good	15	2	3	33	33
* M.N.	36	6 5/12	41	43 1/2	43 1/4	A2	15	Good	18	41 +	2	18	30
A.M.	21	7	63	59	50	A1	2	Good	20	8-4	3	8	14
* K.K.	26	4 7/12	29	46	43	A3	2	Good	29 +	29	2	14	10
A.T.	12	4 6/12	42	35 3/4	38 1/4	A1	67	Good	26	3-2-2	12	21	22
F.K.	13	4 7/12	42	35 1/2	39 1/2	A1	67	Good	14	9	8	9	13
K.Y.	19	2 9/12	14	34	37 1/2	M	67	Frequent infection	18	27 +	4	18 +	18 +
M.G.	2	6 10/12	80	55 1/4	50 1/2	M	15	Good	32	18	35	36	34
* W.C.	11	7 8/12	79	45	46	M	82	Good	23	6	7	22	13
* M.P.	4	8	92	51	48	M	67	Inactive Rh.F.	7	3	2	8	2
T.S.	10	9 2/12	100	59	51 3/4	B1	67	Good	18	3	3	7	14
S.B.	12	14	156	104	65 3/4	B2	67	Good	36	0	12	18	60
C.B.	19	10 7/12	108	71	54 3/4	B1	67	Good	23	5	9	13	9
R.L.	5	9 2/12	105	77 1/2	52 3/4	M	15	Good	43	4	31	1	31
* H.S.	11	9 8/12	105	60	50 1/4	M	67	Excellent	19	2	2	2	?
J.R.	5	8 9/12	100	57 3/4	50 1/4	M	67	Good	55	1 1/2	14	7	3
J.L.	22	8 3/12	77	54	50 3/4	B2	67	Good	26	18	2	10	14
E.C.	12	5 3/12	51	50	44	A3	15	Excellent	24	1 1/2	2	24	51?
* H.J.	19	3 1/12	18					Abandoned Regime - Relapsed - Treated Elsewhere.					

[* Patients with complications on admission.

Physique Channel and Percentile refer to Wetzel Grid.]

turn of irritability or other evidence of relapse. The figures given are for the total number of months, and are not always continuous. The injections of liver extract were continued for between 2 and 6 months in half the cases.

Dietary restriction was continued longer and additions to the diet were made conservatively. The figures given are for the time required to attain a fairly unrestricted diet, as indicated by the parents' answers to the questionnaire. Their replies indicate 1 restricted for 4 months, 1 for 7 months, 8 for 12 to 18 months, 5 for 19 to 24 months, 5 for 25 to 36 months with 3 ranging from 43 to 55 months. Thus the greater number, 18 of the 23, had their diets restricted for from 1 to 3 years with a number of months of weekly liver injections.

The parents were also asked how long before they noticed definite improvement, in general terms not specifying any symptom. Some of them apparently interpreted this to mean an amelioration of symptoms while others interpreted it to mean complete recovery. Their answers are tabulated as given. One was admitted for study and had improved before admission. One reply indicated 1 month, 7 indicated 2 months, 3 from 3 to 4 months, 2 in 8 months and the rest scattered up to 35 months. Eighteen noted definite improvement in 1 year or less.

More specific questions dealt with the duration of abnormal stools and distention of the abdomen. There was a tremendous variation with replies scattered between 1 and 36 months in the case of abnormal stools and from 2 to 60 months of abdominal distention. The prominent abdomen persisted somewhat longer than the abnormal stools, however, as indicated by the average duration of 13 months for abnormal stools as compared with 21 months for the abdominal distention.

Fortunately the prolonged and arduous course of treatment endured by these patients has not been without its compensations. The column headed general health indicates that all of the 23 patients except the one still under treatment are considered by their parents to be in good health.

More specific information is provided in the columns showing heights and weights. These were plotted on the Wetzel grid and their physique channel and percentile are tabulated in the next column. All the patients fell within the middle or upper ranges of normal for their

age, indicating a good to excellent nutritional state and normal size for their age. It must be stated at this point that we have been unable to obtain follow-up information on two of the patients in the original series whom we thought had the poorest outlook. Of the twelve patients with complications on admission seven are included in the group with follow-up information.

We have selected three of the more difficult cases to summarize and present charts showing their courses.

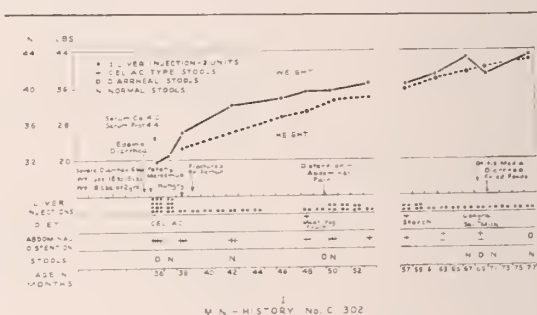
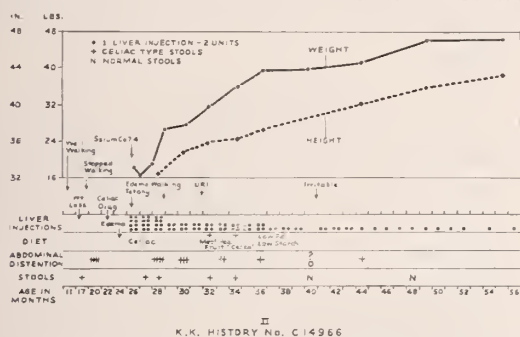


Chart II. K. K. was 26 months old on admission with a history of severe loss of weight and abdominal distention with stools suggestive of celiac disease at the age of 17 months. He was diagnosed Hirschsprung's disease at the age of 20 months and at 22 months diagnosed celiac disease but a strict regime was not instituted. He was admitted in a profound state of malnutrition with nutritional

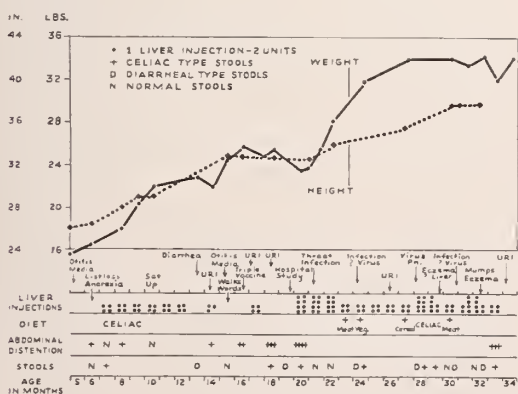
Chart II. K. K. was 26 months old on admission with a history of severe loss of weight and abdominal distention with stools suggestive of celiac disease at the age of 17 months. He was diagnosed Hirschsprung's disease at the age of 20 months and at 22 months diagnosed celiac disease but a strict regime was not instituted. He was admitted in a profound state of malnutrition with nutritional

edema and tetany. His response to a celiac diet and liver injection was dramatic, with a rapid gain in weight and strength. He was walking at the end of 3 months treatment for the first time in 11 months. His liver extract was



discontinued at the end of a year but resumed again because of irritability. His parents state that he became irritable at the end of a 2 week period and this was relieved after the injection. The interval has been gradually increased until now he receives an injection every 2 months because by the end of that period his irritability had returned. There has been no recurrence of his other symptoms and he appears otherwise well.

Chart III. K. Y., a boy of 34 months, is still under treatment. He was put on a celiac regime at the age of 7 months on the basis of a clinical impression and given liver injections once weekly for 5 months. He was doing well and the injections were stopped at 1 year of age. After a diarrhoea and upper respiratory infection at 13 months, he was given 3 weekly injections and began to improve again. A series of colds and otitis media at 15 and 16 months led to another relapse with another series of weekly injections. A recurrence of diarrhoea at 19



months led to a hospital study with confirmation of the diagnosis of celiac syndrome and more vigorous liver therapy, followed by a period of rapid gain and improvement. An older brother of school age has brought home a series of infections which have been accompanied by repeated relapses with diarrhoea. Increase of liver injections to twice weekly led to eczema on two occasions, subsiding upon resuming injections once a week. He is in an improving phase at present but still on a much restricted diet. His height and weight are normal but his abdomen is prominent and he is irritable.

In all three of these patients the addition of crude liver injections to the usual celiac regime seemed to play a very important role. While some patients do well without it or with shorter periods of injections, there is a group of severe celiacs in which its use appears decisive. No attempt is made to explain the element in liver extract responsible for this apparent effect. The analysis given by the manufacturer shows it to contain various members of the B complex but administration of vitamin B complex from other sources has not seemed to give as satisfactory results as the crude liver extract. There are of course numerous other unidentified constituents of crude liver extract.

It is difficult to make a satisfactory comparison of these results with most of those reported. Some of earlier series include cases of cystic fibrosis of the pancreas, a different disease with a much poorer prognosis. Patterson, Pierce and Peck (25) report their experience with 26 cases using a normal diet with liver extract and vitamin B complex administered parenterally for periods ranging from 12 to 38 weeks. They were able to produce weight gains and improved general appearance consistently with return of stool fats to normal in 18 of 26 cases. Their report covers only one year and is difficult to compare with our experience. Haas (26) has recently reported a series of 603 cases with results that may be considered comparable or better in success with the use of similar dietary measures, omitting liver extract. His diagnostic criteria were not as strict as those used in this series but his experience has a good practical lesson. Not all the patients who have suggestive stools, loss of weight, irritability and protuberant abdomens need to undergo the study to which these patients were subjected. There are such in-

stances in most physicians' experience where the basic regime described—skimmed or half-skimmed milk, cottage cheese, ripe banana, lean meat and some fruit with the addition of water soluble multiple vitamin mixtures and possible elixir of ferrous sulfate—will provide an adequate nutritionally sound diet on which the child will thrive and grow with normal stools and a good disposition. The question as to whether he was actually or potentially a case of the celiac syndrome of the type described here may be left in the realm of conjecture. There are certainly a number in which this eventuality may be forestalled by the institution of such a regime. If the response is not prompt and complete, however, it must be said that a stool study confirming the diagnosis gives both physician and parents the confidence necessary to carry out the prolonged course of diet and injections so essential to the successful treatment of the moderately severe celiac syndrome.

Summary

The differential diagnosis between the idiopathic celiac syndrome and cystic fibrosis of the pancreas has been briefly discussed, pointing out that the symptoms in the celiac syndrome arise from defective intestinal absorption while in cystic fibrosis there is a deficiency of pancreatic enzymes. Thirty-seven patients, ten of them with secondary nutritional disturbances, were seen in the Grace-New Haven Community Hospital between 1941-50. All were treated with the usual dietary regime with the addition of crude liver extract injections. Follow-up information on twenty-three patients indicate the complete recovery of 22 while 1 is still under treatment. Liver extract injections ap-

pear to be a valuable adjunct to the dietary treatment and in severe cases may be decisive.

(Note: This study was undertaken at the suggestion of Drs. G. F. Powers and D. C. Darrow. Dr. Victor C. Vaughan III examined the patients who returned to the clinic for follow-up.)

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Diagnosis of Diabetes Mellitus

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Diabetes rates eleventh as a cause of death in the state of Kentucky. In 1951 there were 372 deaths per 100,000 population which gives a rate of 12.4 per cent. This compares favorably with the rate of the whole United States, which was estimated at 16.5 per cent in 1951.

The median age at death from diabetes mellitus in 1915 in Kentucky was 59.5 years, compared to 67.4 years in 1951, which is indicative of the prolongation of life of diabetic individuals, due to earlier diagnosis and adequate care. It is estimated that there are at least one million unrecognized diabetics in the United States; this represents a tremendous opportunity for the practice of preventative medicine by early diagnosis.

Preinsulin Period Diagnosis

Before the advent of insulin, diabetes was not often diagnosed by the development of the cardinal symptoms of polyuria, polydyspia, polyphagia, loss of weight, pruritis and fatigue. The onset of these symptoms may have been either insidious or abrupt. At the present time it is unusual for a physician to see a patient with all of these symptoms on their initial visit to him. More often the patient is found to have glycosuria on a routine annual physical examination, life insurance examination, or as a result of diabetic detection campaigns.

Symptoms of Unrecognized Diabetes

The mild undiscovered diabetic will be brought to light by an acute infection or trauma, which interferes with insulin function and rapidly intensifies the symptoms, even to the degree of diabetic coma. In this case the symptoms will be headache, anorexia, nausea, vomiting, increased thirst, abdominal pain, drowsiness, and finally coma. A fruity odor of the breath and the characteristic deep rapid respiration of acidosis will assist in the diagnosis. A visual defect may bring the patient to the doctor's office and may be due to one of the many complications of diabetes, namely retinitis, glaucoma, or cataract. Coronary artery disease, peripheral vascular disease, neuritis, menstrual

difficulties, sterility and impotence are also complications of diabetes and the true cause may not be known until a proper blood sugar examination has been made. General weakness, loss of weight, frequency of urination, and pruritis are among the more frequent complaints that cause the patient to seek assistance. These symptoms require the elimination of diabetes as a cause. Hyperthyroidism, acromegaly, Cushing syndrome, all carry a high incidence of associated diabetes. Even if the first sugar tolerance tests are normal in these cases, it must be remembered that diabetes may develop later and they must be re-examined from year to year. The same attitude should be adopted in dealing with gall-bladder and liver disease.

The physical signs of diabetes are often absent in the robust healthy diabetic individual. Many of them are obese, without other signs. The more seriously ill patients will appear fatigued, and the skin will show loss of subcutaneous fat. A ruddy complexion is a frequent finding in a diabetic. Inflammation of the vulva or glans penis requires the elimination of diabetes as a cause.

Diagnosis

The foregoing symptoms, signs and diseases will lead the alert physician to a diagnosis of diabetes, but blood sugar studies are necessary to definitely establish the diagnosis. Glycosuria, even on repeated examinations, is not of value in making a diagnosis of diabetes. A low renal threshold for sugar has led many individuals into being treated for diabetes when no hyperglycemia was present. This must be guarded against. Hyperglycemia, not glycosuria, is the crucial point in the diagnosis of diabetes. A fasting blood sugar within normal limits should not be accepted as eliminating a diagnosis of diabetes. Fasting blood sugars are very misleading because it is possible for mild diabetics to have normal fasting blood sugars and the correct diagnosis may be missed, thus permitting the disease to advance to a frank diabetic state which may become irreversible.

Glucose Tolerance Test

A glucose tolerance test in some form is the only satisfactory means of establishing a correct diagnosis. To be able to accurately interpret a glucose tolerance test one must be aware of the normal reactions to a high carbohydrate intake. A fasting blood sugar should range between 80 and 120 mgs. per 100 cc. of blood. The venous blood sugar usually does not rise over 200 mgs. in 2 hours (venous blood sugar values Folin-Wu method).

The usual technic of tolerance test: One dose test lasting 2 or 3 hours.

Procedure: See that the patient has eaten a liberal amount of carbohydrate and has received no insulin for at least 3 days before the test. Give 100 Gm. of dextrose in 500 cc. of water; for children under 100 pounds—1 Gm. per pound.

Test the urine and blood sugar before, in $\frac{1}{2}$ hour, 1 hour, 2 hours, and 3 hours afterward (some physicians omit the 3 hour test).

Normal results: The venous blood sugar usually does not rise over 200 mg. and returns to below 120 mg. in 2 hours (venous blood sugar values Folin-Wu method).

The preparation of the patient for a glucose tolerance test is most important. He must have been on a normal carbohydrate diet for at least three days before the test, and must not have taken any insulin during this time. Certain conditions will produce a suggestive diabetic tolerance curve and should be considered in interpreting the results. These are marked nervousness, acute infections, freak diets, prolonged fasting. Placing the patient on a normal diet for a week will correct such abnormal curves unless the patient is a diabetic. Any condition that will prolong the absorption of glucose from the stomach or intestinal tract, such as nausea, pylorospasm, and diarrhea will produce an abnormal curve. If the absorption of glucose by the oral route is not considered accurate, then 50 cc. of 50% glucose may be given intravenously within a period of three to five minutes and blood specimens taken at one-half, one, and two hour intervals.

Interpretation of Tolerance Test

A fasting blood sugar of over 120 mgs. suggests that the patient may be a dia-

betic and a glucose tolerance test should be performed.

If the blood sugar rises above 200 mgs. at one hour and does not return to 120 mgs. or lower at two hours, then the patient is considered to be a diabetic.

A two hour reading between 120 and 130 mgs. places the patient in a potential or mild diabetic group. Such an individual may not develop frank diabetes but periodic examination must be made to protect him.

Instead of a standard glucose tolerance study one can depend on a post-prandial blood sugar for diagnosis. The blood sugar determination is made two and one-half hours after a normal carbohydrate meal. A blood sugar of 200 mgs. or more at this time indicates that the patient is a diabetic and no further diagnostic study is necessary. A blood sugar of 140 to 150 mgs. is suggestive, but not diagnostic. In such a case a standard glucose tolerance test should be performed.

Value of Early Diagnosis

It is our opinion that some form of blood sugar determination should be included in the routine laboratory study of each patient, either a post-prandial blood sugar by the Folin-Wu method or the Wilkerson Heftmann method. Many unsuspected diabetics will be found by this additional screening. A full blown diabetic is not difficult to detect. The need is to recognize the milder subclinical forms so that treatment can be instituted early. Early treatment will assist in maintaining the integrity of the pancreatic insulin function preventing its deterioration by prolonged hyperglycemia. This is especially important in children and young adults.

The American Diabetes Association has helped discover many unrecognized diabetics in its Diabetes Detection Drives throughout the country. The early diagnosis of diabetes in children and adults presents a great opportunity for the physician to practice preventative medicine.

Summary

The death rate in the state of Kentucky from diabetes has been given with the median age at death. It is observed that the median age has increased 7.9 years since 1915. Diabetes rates eleventh as a cause of death. The symptoms of diabetes are discussed with the observa-

tion that they are more often absent than present in this era.

Glycosuria should not be considered final evidence in the diagnosis of diabetes but only indicates the need for further investigation. Hyperglycemia is the diagnostic feature of diabetes. A normal fasting blood sugar does not exclude diabetes. Some form of glucose tolerance test is needed to make a definite diagnosis and

the procedure recommended by the American Diabetes Association is outlined.

Potential diabetics should have periodic examinations. It is recommended that the post-prandial blood sugar examination be made a part of the routine laboratory examination.

The value of diabetes detection drives is recognized and it is recommended that all physicians assist in this work.

The Modern Treatment of Diabetes Mellitus

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Objectives

The physician treating diabetes has four objectives in mind: (a) to relieve symptoms, (b) to keep his patient in a state of normal nutrition, (c) to conserve what remains of the insulin producing power of the pancreas and (d) to avoid complications.

In most cases the relief of symptoms is so easy that it is dangerous. Moderate restriction of carbohydrate and the use of a long lasting insulin once a day are enough to abolish thirst and polyuria. Unfortunately, such improvement may take place while the urine continues to show large amounts of sugar, and since the patient now feels better, all too often neither he nor his doctor is convinced that more rigorous treatment is necessary. Therein lies the danger, as we shall see shortly.

The attaining and maintaining of normal body weight is not difficult if the patient is cooperative. The thin diabetic must be given a diet which will permit him to gain even if it means 3000 to 4000 calories per day; glycosuria can be controlled with insulin. A much more common and more serious problem is the fat diabetic. The penalties of obesity, even for the nondiabetic, in terms of higher mortality during illness, shortened life span and greater susceptibility to cardiovascular disease, are well known. In the diabetic these hazards are multiplied, especially with respect to the heart and arteries, and reduction of excessive body weight is imperative. There is the further incentive that in many obese women with relatively mild diabetes the disease all but disappears when weight is returned to

normal. "Reducing diets" must be realistic. It is not true that 1200 calories is a suitable allowance for all fat people. It is good for the overweight stenographer, but the 250 pound farmer will lose very nicely on 2000 calories and will surely cheat if he is given less.

Our third objective, to preserve the insulinogenic power of the pancreas, implies that this power is regularly impaired in diabetes. This notion, once generally accepted, was for a time in danger of being overwhelmed by the newer knowledge of the pituitary and the adrenal cortex and the role they played in carbohydrate metabolism. More recent observations have refocused attention on the islets of Langerhans. It has been reported from Toronto (1) that, in diabetic patients coming to autopsy, the amount of insulin which can be extracted from the pancreas is on the average less than half of that found in the pancreas of the non-diabetic. Significantly, the glands of patients who acquired the disease in childhood yielded less than one-tenth of the insulin found in the adult diabetic pancreas and a much smaller fraction of the insulin contained in the normal pancreas. This finding is consistent with the clinical characteristics of the juvenile diabetic who behaves indeed as if he were unable to produce any insulin of his own. It is compatible also with the studies of Bornstein and Lawrence (2) who, using a newly perfected technic for determining minute amounts of insulin, were unable to find any of the hormone in the blood of younger, severely diabetic patients with ketosis as contrasted with small but definite amounts in older, obese patients with milder diabetes.

Such evidence of insulin deficiency in diabetes clearly means that in every case of recent onset, if not in case of longer duration, the pancreas should be protected against further depletion of its resources, for the patient with no endogenous insulin is in a far more precarious state than the patient with some insulin reserve. How is this protection to be accomplished? We may take our cue from certain experiments with animals. It has been shown that if the beta cells of the islets are damaged by one means or another to a point just short of actual diabetes, full-blown diabetes will result from subsequent measures which lead to persistent hyperglycemia, i. e., the remaining beta cells are exhausted by the increased load they have to bear and eventually succumb (3, 4). On the other hand, damage to the beta cells just sufficient to cause diabetes may be reversed, with recovery from the disease, if hyperglycemia is prevented early by insulin, starvation or other methods (5, 6, 7). Clinical experience, while not so clear cut, is in accord with these observations. Every effort should be made, therefore, to conserve the insulin producing capacity of the pancreas by the strict avoidance of hyperglycemia. In younger patients, in whom this is especially important, the task is often difficult, but it should always be attempted.

The prevention of complications is the physician's fourth objective. Today we regard vascular disease as the greatest problem in diabetes. Seventy-five per cent of diabetic deaths are caused by such disorders as coronary occlusion, cerebral hemorrhage or thrombosis, gangrene and intercapillary glomerulosclerosis, and the majority of patients who have had the disease for fifteen to twenty years have retinal hemorrhages. The reasons for the susceptibility of the diabetic to vascular degeneration are not known. Whether the degree of control of glycosuria is related to the incidence of such tragedies is a question which has not been finally answered, but the best evidence we have suggests that this is the case. Although premature arteriosclerosis is occasionally seen in mild, well controlled diabetes, there is no doubt that the most advanced lesions are seen in severely diabetic patients with poorly controlled glycosuria of many years' standing. Wilson, Root and Marble (8) recently reported a study of retinopathy in 103 cases of diabetes of

twenty or more years' duration. The degree of diabetic control was estimated from the patients' histories and hospital records and was graded excellent, good, fair or poor. The severity of the retinal lesions was graded as none, minimal, moderate or marked. Of the four patients with excellent control, 3 had no retinopathy and 1 had minimal lesions. By contrast, of the 58 patients with poor control, 40 had moderate or marked lesions and 18 minimal or no lesions. This study, carefully made and documented, confirms the clinical impression of most physicians that good control minimizes or delays such complications, if it does not entirely prevent them, and that poor control exaggerates and accelerates them. It cannot be maintained that hyperglycemia and glycosuria in themselves are responsible, but it is reasonable to assume that they reflect other metabolic abnormalities associated with poor control, including disturbances of lipid or protein metabolism, which may affect blood vessels adversely.

In the current interest in vascular disease and its relation to good or poor control, it is sometimes forgotten that certain complications of diabetes are unquestionably the result of excessive sugar in the blood or urine. Chief among these are the infections of the genitourinary tract, especially in women, and cataract in young people. Diabetic neuritis occurs principally in neglected diabetes and rarely abates without careful regulation of the blood sugar. Diabetic coma, while not caused by hyperglycemia alone, never occurs without it.

Treatment

It is evident that the objectives which have been outlined can best be achieved by careful attention to diet and insulin.

DIET. The previously untreated ambulatory diabetic should receive at first a diet containing 100 to 150 grams of carbohydrate per day. This relatively low figure provides optimum opportunity for the patient to get along without insulin and yet is not too low to be unpalatable. One gram or more of protein per kilogram of body weight is given, together with enough fat to meet caloric needs. The diet must be quantitative. Whether it is measured by common kitchen utensils or by weight is a matter of preference. For many physicians the most troublesome part of diet therapy is translation of the

grams of carbohydrate, protein and fat into portions of actual food. This has been simplified in the "Diabetes Guidebook for Physicians" published recently by the American Diabetes Association. A "diet list" should never be handed out without explanation.

URINALYSIS. At the same time the patient is instructed in his diet, he is taught how to test his urine for sugar at home. This is absolutely necessary for the proper management of the disease. The tests are made for the first few weeks four times daily,—on arising and three hours after each meal, and a record of the results is presented at each office visit. Benedict's *qualitative* solution is preferred, but under some conditions the use of tablets is permissible provided they are fresh.

DIABETIC MANUAL. The patient will not remember everything he is told at the first visit. A good manual, of which several are on the market, should be required reading and the patient should be quizzed on its contents at subsequent visits.

Equipped with these instructions, all of which can easily be given in the office, the patient is allowed to go home. He is asked to return every one to two weeks, bringing with him a record of his urine tests, a record of food eaten and a specimen of a complete 24-hour collection of urine made the previous day. This specimen is analyzed quantitatively for glucose. Such analyses provide valuable information as to the significance of the home tests, for a 4 plus qualitative test may mean anywhere from 2 to 10 per cent sugar.

The procedure after the second visit depends upon the results of the home tests and the patient's weight:

1. Home tests sugar-free

- a. Patient obese: Continue original low carbohydrate diet but restrict fat as necessary for weight loss.
- b. Patient of normal weight and maintaining it: Original diet is continued for a few weeks, then carbohydrate gradually added and fat reduced. If glycosuria reappears, return to next lower carbohydrate allowance.
- c. Patient originally of normal weight but now losing, or

d. Patient already at subnormal weight: Carbohydrate and calories are increased as necessary to regain normal weight, and if glycosuria results, insulin is given.

2. Home tests show considerable sugar after one or two weeks on diet.

- a. Patient obese: If there are no symptoms, a low carbohydrate, low calory diet is continued until considerable weight loss occurs. This often abolishes glycosuria. If it does not do so in one month, insulin should be given.
- b. Patient of normal or subnormal weight: Carbohydrate should be increased, calories adjusted as necessary, and insulin prescribed.

INSULIN. In general, *when a diet designed to correct abnormal body weight or to maintain normal body weight fails to render the urine essentially sugar-free after two to four weeks, the use of insulin is indicated.*

Insulin should be given one-half hour before breakfast in a single scale syringe graduated for either U-40 or U-80 insulin, *not both*. Needles should be No. 25 gauge and 5/8 inch long. Any patient who has previously taken insulin should be compelled to bring in his own syringe for inspection so that the physician can ascertain that its use is thoroughly understood.

For most patients NPH insulin is the best form available. Its peak of activity occurs in the afternoon and its effects usually persist for 24 to 28 hours. The carbohydrate of the diet should therefore be distributed between the principal meals in a proportion approximating 20-40-30-10 per cent, the last being the bedtime feeding. The beginning dose of NPH insulin should rarely exceed 10 to 20 units daily. It should not be increased for at least a week. Thereafter, if satisfactory results have not been obtained, the dose may be raised 3 to 5 units every 3 to 5 days until either the rising of the afternoon urine test is clear. If now glycosuria persists after breakfast or after supper, a small dose of regular or crystalline insulin should be given before the meal in question, but never at bed time when NPH or protamine zinc insulin is being employed. The technic of adjusting insulin and diet is illustrated in the table.

MILD DIABETES

No insulin

	B	L	S	BT
CHO 100 Gm.	33	33	33	
Urine	0	++	++	++

10 u. NPH

CHO 150 Gm.	35	60	40	15
Urine	0	tr	0	0

SEVERE DIABETES

No insulin

	B	L	S	BT
CHO 100 Gm.	33	33	33	
Urine	++++	++++	++++	++++

10, 20, 30 u. NPH

CHO 200 Gm.	50	70	60	20
Urine	0	+++	+	0

30 NPH + 10 R

CHO 200 Gm.	50	70	60	20
Urine	0	tr	0	0

The "brittle" diabetic deserves special mention. Such patients usually exhibit wide fluctuations of the blood and urinary glucose even when confined to the hospital with diet, activity and insulin constant. In such cases the urine tests often fail to reflect the rapid swings of the blood sugar. The latter must therefore be determined often enough, and at various times of the day, so that the extremes of its excursions are known, and the dose of insulin must be such that the lowest values for blood sugar never fall below 100 to 150 milligrams per 100 cc. To per-

mit lower levels is to invite hypoglycemia. Such a program will inevitably result in considerable glycosuria some of the time. This is a regrettable departure from the standard of strict control which we have proposed, but insulin shock is worse. In this type of patient it may be wise to give regular or crystalline insulin two or three times daily with only a minimal dose of protamine zinc insulin in the morning, rather than to rely on any long lasting insulin as the major instrument of control. Another method which has met with success is to give NPH or globin insulin before breakfast and at bedtime, the latter dose being one-third to one-fourth of the morning dose. At best, the "brittle" diabetic is a knotty problem which demands the closest cooperation between the patient and his doctor.

Summary

The objectives of treatment in diabetes are for the most part attainable by careful attention to diet and insulin to the end that the blood and urine sugar are controlled as strictly as the avoidance of hypoglycemia will permit.

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Surgery of the Patient with Diabetes Mellitus

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Since the purpose of this paper is to consider surgery of the diabetic patient in a general manner, detail is not a keynote, rather the basic principles are set forth.

General Facts

It seems advisable at this point to mention certain generalizations which are worth remembering about the diabetic patient. First amongst these is that fifty per cent (50%) of all diabetics will need surgery at some time or other. Another such fact: twenty-five per cent (25%) of all diabetics have cholelithiasis where as only twelve per cent (12%) of the normal population has gallstones. Acidosis can, and frequently does, cause signs and symptoms which simulate an acute surgical abdomen, particularly is this true just before coma. Acute appendices rupture early in the diabetic patient, and the signs and symptoms are misleading because of their mild character. Infection is not more prevalent in the patient with diabetes. However, when present, its progress is more rapid, the organisms multiply faster, and diabetic control is lost much quicker. Toxic goitre is incompatible with diabetes since the high metabolism prevents control of the glycemia. This action is accomplished by the preventing of the storage of glycogen in the liver. Also thyroxin has an antagonistic action to insulin. Carcinoma of the pancreas has been found in one third (1/3) of the patients who died of diabetes. Hypertension is so frequently found to be associated with diabetes, that it is almost expected in the patient past middle age. Vascular complications, except for the extremities and the eye, are cared for best medically. Preoperatively, the degree of arteriosclerosis should be noted carefully; particularly is this true of the heart and kidneys. The actual incidence of these vascular complications is lowered by the early control of the patient's diabetes. Coronary Occlusion appears to be precipitated in the elderly diabetic when the blood sugar is lowered either too suddenly or too low. Severe Trauma, especially

fractures, are tolerated poorly by the diabetic. This is evidenced by the fact that a patient may be sugar free and under good control with twenty to thirty (20u-30u) units of insulin daily, while after a major fracture he may require seventy to one hundred (70u-100u) units daily.

Bell analyzed all the post mortems at the University of Minnesota from 1910 through 1947. There were 28,240 males and 15,119 females over 10 years of age. He found that atherosclerotic gangrene is thirty-eight times as frequent in diabetics as in nondiabetic males, and forty times as frequent in diabetic as in nondiabetic females. He further stated that gangrene of the extremities is twenty-five times as frequent in diabetic as in nondiabetic females, and that there was more than an even chance that an elderly female with gangrene has diabetes.

Lastly amongst these listed generalizations of the diabetic patient is that surgery is more dangerous in them only because of the fundamental weaknesses which the disease causes: (a) Metabolic imbalance, (b) Liver function failure, and (c) Vascular disease. Further, with proper evaluation and preparation, which in essence means control of the diabetes, all forms of surgery should be made available to these patients. By all forms of surgery is meant not only emergency but also elective operative procedures; the latter to include plastic and reconstructive surgery. With adequate control of the diabetes, the diabetic is just another patient who may benefit by surgery.

Surgical Diseases

Really there are only two of these which are secondary to diabetes mellitus: carbuncle and gangrene. The latter is either of the dry type arterio-sclerotic, or the wet which is infective. A combination of the two, however, is usually most frequently found. As mentioned above, cholelithiasis is twice as common in the diabetic patient as in the normal individual. Also toxic goiters must be treated

promptly in the patient with diabetes mellitus.

Treatment

The keystone to successful surgery in these patients is adequate control of the diabetes mellitus and good preoperative care. In elective surgery, evaluation of the degree of arterio-sclerosis, particularly in those organs most affected: the kidney and heart, should receive thorough study. Prompt therapy should be instituted when indicated. The judicious and adequate use of parenteral fluids, whole blood and/or plasma, antibiotics and vitamins are general surgical principles applicable to all patients, and are enumerated here only for emphasis.

Emergency surgery presents the same problems except that the maximum benefit must be obtained in the minimum time. Acidosis should be corrected prior to surgery and an elevated blood sugar alone should cause no concern, especially if 200 mgms/c.c. or lower. On the contrary, too sudden and low a depression of the blood sugar should arouse concern and be guarded against. Protamine insulin should be changed to regular insulin until the patient is stable postoperatively. The differential diagnosis of the acute abdomen and a patient ready to enter coma is reiterated as a warning to unnecessary surgery. In an acute abdomen, our good friends, the intestinal decompression tubes, are invaluable.

The technique in a patient with diabetes must be meticulous. It should include the basic principles of no mass ligatures, complete asepsis, complete hemostasis, and care to prevent soilage of the wound edges.

Carbuncle

The treatment of carbuncles has been simplified and shortened since the advent of the antibiotics. There are those who treat them with x-ray therapy alone, others who use antibiotics and roentgen therapy. Unless this lesion is seen early, however, there are certain of these patients who will require surgical drainage. Still others treat carbuncles by surgical excision. Probably the most efficacious therapy is: early large doses of penicillin and late, complete surgical drainage.

Gangrene

This condition necessitates amputation which in turn is determined by the vas-

cular disease present. Here again the antibiotics have been a great help not only in lowering the site of amputation but in the actual saving of life. Up until 1934 one half ($\frac{1}{2}$) of major amputations died because of the lack of control of the infection. Any infection present should be controlled prior to amputation. In the preparation of these patients for surgery it is best to refrain from heat locally since in a patient with marked arteriosclerosis, the heat increases tissue metabolism without increasing the blood supply. It is better to use a cold pack which is mildly antiseptic yet not irritating. Such a solution consisting of half saturated boric acid and half 70% alcohol is very good. In the management of these cases we are constantly striving to increase the blood supply to the extremities. When the infection is controlled, the surgeon can evaluate the circulation of the extremity and amputate as low as possible. Clinical criteria are as good as the laboratory in this evaluation. These criteria are: the level at which a pulse is felt, i. e., femoral, popliteal, or dorsal pedis arteries; the degree of ischemic rubor on dependency; the presence of unrelieved rest pain; and at the time of surgery the presence of poor bleeding. Formerly it was thought that nothing less than a mid-thigh amputation was necessary for various circulatory deficiencies of the toes and foot. It has been said that diabetics develop changes in the arteries a decade earlier than do nondiabetics. Wherever possible the transmetatarsal amputation advocated by McKittrick should be employed. Even if it appears clinically that failure is more likely than success, it is wise to employ this type amputation, provided that such failure is recognized early and higher amputation is done. The obvious reason for such an operation is the functional result obtained. By far, most cases notice very little if any handicap in the partially amputated foot following surgery. Due to the arteriosclerosis present, tourniquets best not be used.

Lumbar Sympathectomy

Lumbar sympathectomy will increase the blood flow to these extremities in a certain select group. Worthen reports that one half of his patients have been benefited by lumbar sympathectomy.

DeTokats stresses that the removal of the lumbar sympathetics chain frees the corresponding extremity from fluctuation

of basomotor tone. Coller reported that the benefit of a lumbar sympathetic block on sclerotic vessels is not from the release of the so-called spasm but from the effect of the block on the release of the functional factor.

Many writers agree that the results derived from sympathetic block are not directly proportional to the result one might obtain from a lumbar sympathectomy. These failures of the block to produce an improvement in circulation might be due to poor technic as well as differences in innervation. Cole reports seven patients who had sympathectomies for pain but with poor vascular tests. Six of these patients had good or excellent results and returned to work. The other patient had to have an amputation later. The results of the block are more temporary and do not give a permanent interruption so necessary to produce improvement. Many times diabetic toes may be allowed to demarcate and self amputate. A varidose paste will sometimes help in the self amputation of these toes.

Leg Amputation

Leg amputations produce end bearing stumps and are much more desirable than thigh amputations. In a great number of cases, the leg amputation, preferably 8 to 10 inches below the knee, will give the patient the most useful stump.

Siebert and Haimovici list the following indications for mid-leg amputation for gangrene in diabetics:

1. Cases in which transmetatarsal amputation of one or all toes has failed with necrosis spreading toward the ankle.
2. Cases with gangrene of several toes extending to or beyond the adjacent metatarsal regions and showing no tendency to demarcate.
3. Cases with spreading gangrene of the toes associated with extensive gangrene of the heel or above the ankle.
4. Cases with spreading gangrene of several toes associated with uncontrollable infection of the foot.
5. Closed type amputation used except in widespread and uncontrollable infection.

He further lists as contraindications the following:

1. Extensive gangrene and infection of leg and absence of femoral pulse at groin.
2. Gangrene of foot with flexion contracture of knee joint.

3. Recent thrombosis of femoral artery.

One may expect healing in these leg amputations by primary intention in 3 to 4 weeks with primary closure of the stump and the use of antibiotics. The hospital mortality runs from 4 to 6 per cent.

Postoperative Care

Here again those basic principles which are applicable to all patients are employed. The control of the diabetes mellitus and prevention of toxic psychosis, which so frequently follows major amputations, demand special attention. Postoperatively, as preoperatively, in treating the diabetes mellitus, it is better to err in giving too little rather than too much insulin. It is much safer for the patient to run a little sugar in the urine than not; for in this way insulin shock is prevented. Though it should be prevented, the ability to recognize insulin shock by all the hospital personnel handling the patient, should be common knowledge. To assure this, it is always wise to refresh the memories of those concerned. Always run a blood sugar when in doubt.

A very practical way to regulate the sugar is the running of a urine sugar every four (4) hours. If the test is red give 15u of regular insulin, yellow give 10u, yellow-green give 5u. Oral feedings should be started postoperatively as soon as tolerated.

Early ambulation plus the vitamin B complex, particularly nicotinic acid, help considerably the toxic psychoses.

Before the amputation the patient is told that he is expected to be ambulated early on crutches. Further instructions are given him that a prosthetic appliance will be fitted and worn by him very early in his postoperative period. This is most helpful from the psychological rehabilitation of the patient and he is more ready to accept his later handicap.

Conclusions

1. A resume of the surgical aspects of the patient with diabetes mellitus has been presented.
2. Emphasis has been placed upon the fact that patients with this disease should enjoy the benefits of all surgery as long as their diabetes mellitus is under control.
3. A plea is made for conservation in extremity amputation.

Treatment of the Malignant Lymphomas By Radiation Therapy and Chemotherapy

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We have all seen patients with Hodgkin's disease and lymphosarcoma, whose clinical course was so acute that the period from initial symptoms to generalization and death was only a few weeks. We have seen others in whom the condition advanced so slowly and insidiously that it remained undiagnosed and untreated for years. The natural history of the untreated disease influences not only the length of time the individual lesion remains localized, and accessible to curative therapy, but also affects clinical progress after generalization. One speaks of "curative treatment" only in cases where the disease is localized, because adequate doses in the order of 2,500 to 3,000 roentgens can definitely sterilize the localized lymphoma. However, if large sections of the body, or the entire body, are involved, adequate dosage to these large areas is not tolerated. A radioactive isotope has not yet been discovered which will concentrate selectively only in the cells of Hodgkin's disease and lymphosarcoma without affecting normal cells. Injury to a large number of normal cells is unavoidable if sufficient dosage is given to arrest these diseases permanently by the use of total body roentgen therapy, radioactive phosphorus, or nitrogen mustard. If dosage is reduced so as to diminish the damage to normal tissues, the weaker treatment suffices only for temporary growth restraint of the diseased tissue, and must be repeated as required by symptoms. With each repetition of therapy, tolerance is further decreased, and finally the disease overwhelms the patient. The occasional long survival in generalized cases of Hodgkin's disease, or lymphosarcoma, may be due more to the natural tendency of the untreated disease to progress slowly than to the effect of local or general treatment.

I believe it would be advisable in a discussion of treatment of lymphomas to separate Hodgkin's disease from lymphosarcoma, as their clinical courses, prognosis, and management, vary somewhat.

Hodgkin's Disease

It is believed by some that Hodgkin's disease may sometimes appear as a unicentric lesion, as evidenced by a small mass limited to one glandular area. If this lesion is superficial, there are some who advocate that this lesion should be attacked surgically, and then followed by deep x-ray therapy. There are now a fair number of cases reported which were managed in this manner with 10, 12 years, and even longer cures. Lenz and Stout, however, maintain that radical or obliterative roentgen treatment, not preceded by surgery, can accomplish the same results if the disease is truly unifocal. Regato argues further that if surgery is completely adequate to eradicate unifocal disease, then why should the surgery be followed by irradiation. However, it remains that the present day practice in most centers is for complete surgical extirpation, followed by radical roentgen treatment.

It is almost universally agreed that Hodgkin's disease, which is confined to one part of the body, such as neck nodes with mediastinal involvement, is best treated by radio-therapy. Such x-ray treatment gives longer remissions than does nitrogen mustards or any other chemotherapeutic agent.

In the late stages of the disease, when the lesions are so generalized, or become radio-resistant, nitrogen mustard becomes a valuable therapeutic agent in the management of Hodgkin's disease. I should like to explain the term "radio-resistant" when used in discussing lymphomas. Generally, it is not that the Hodgkin's lesions do not respond to the effects of ionizing radiations, but usually, late in the disease, skin tolerance in the areas of the disease have usually been reached, so that it becomes unwise to give additional radio-therapy through these areas.

And so it is at this stage of so-called "radio-resistance," or because of extensive generalization of the disease, that nitrogen mustard may be employed. In about 75% of cases, a remission is obtained, and an additional short period of active life

results. The remissions, however, are not long lasting, and usually the disease shows less response to additional courses of nitrogen mustard.

There are probably two instances in which localized Hodgkin's deposits do better with the injection of nitrogen mustard than with radio-therapy.

- a. Dural deposits, causing partial or complete paraplegia, usually respond well.
- b. Mediastinal masses, causing superior vena cava obstruction, or tracheal obstruction, may shrink after nitrogen mustard therapy, without the initial swelling that is sometimes said to follow irradiation.

Incidence of Herpes Zoster

The incidence and significance of Herpes Zoster in patients with lymphomatous diseases is interesting. In one large series, 7% of patients with Hodgkin's disease, and 4% of patients with lymphosarcoma, had Herpes Zoster in the course of their disease. Survival time was longer than average in patients with Herpes Zoster; thus in Stout's and Lenz's cases the average survival time was 8 years. Could it be that Herpes Zoster occurs primarily in slowly progressive chronic cases? Further study will be necessary to determine this point.

As for prognosis of Hodgkin's, the figures in different reported series vary from 10 to 30% of patients alive at the end of 5 years who are free from symptoms.

Lymphosarcoma

This disease may be separated as follows:

1. Localized disease originating in a mucous membrane, such as in nasopharynx or tonsil.
2. Regional lymphatic extension from a recognized primary focus. According to Stout, about 1/3 of the lymphosarcomas are extra-nodal in origin.
3. Regional lymph node disease, originating in the nodes.
4. Generalized lymphosarcomatosis.

This division is significant because the first three forms of the disease are curable before generalization occurs. After generalization, the prognosis drops considerably. Thus, many series reported for

localized disease, show 35 to 40% five year survival rate, but after generalization of the disease occurs, only 5% survive 5 years.

In localized lymphosarcoma the treatment of choice is radio-therapy. It is only when the disease becomes generalized that nitrogen mustard or other chemotherapy might be tried. In general, the results with nitrogen mustard are not nearly as good in lymphosarcoma as in Hodgkin's disease.

Giant Follicular Lymphoma

If this is localized to a superficial area, surgery followed by radiation, or preferably radical or obliterative radio-therapy, should be used. The latter is preferred because this lesion is probably the most radio-sensitive of all lymphomas. It also has the best prognosis of all the lymphomas because the natural history of the disease is that it is a slow growing lesion. However, once the disease becomes frankly sarcomatous, the disease progresses rapidly. Radiation therapy should still be used until the advanced stages, when nitrogen mustards may again be indicated. As a rule, remissions are short.

Mycosis Fungoides

This is considered by many to be a variety of lymphosarcoma of the skin, which often goes on for years. The lesions, however, finally break down and fungate. The response of mycosis fungoides to roentgen therapy is similar to that of other types of generalized lymphosarcoma. We believe that radio-therapy should always be used first, but when the disease becomes generalized, with breakdown of lesions, nitrogen mustards should be tried.

Chemotherapeutic Agents

Intravenous Nitrogen Mustards

The therapeutic use of nitrogen mustards, like that of roentgen therapy, is based on arrest of the growth and reproduction of the lymphomatous cells. During the first one to eight hours after intravenous administration there may be anorexia, nausea, vomiting, and diarrhea. For the next few weeks there may be reduction of red blood cells and hemoglobin, which return to normal levels in about six weeks. Lymphopenia and thrombocytopenia may occur during the second and third weeks after administration.

The usefulness of nitrogen mustards is limited by the concomitant damage which they produce in bone marrow, intestinal mucosa, and other normal structures. This is in contrast to roentgen therapy when applied to one section of the body where there is a minimum of damage to the bone marrow and normal structures. In other words, nitrogen mustard is always a generalized toxic agent, whereas roentgen therapy gives essentially the same effects but over a localized area.

Regeneration of the bone marrow depends on its status before the treatment, and the dosage that has been administered. Ordinarily, regeneration starts three weeks after the first treatment.

As already pointed out previously, nitrogen mustards are used chiefly in the treatment of disseminated Hodgkin's disease, generalized giant follicular lymphosarcoma, and disseminated lymphosarcoma. There is general improvement of the patient with symptomatic relief, if the treatment is successful. The average remission in Hodgkin's disease, with the first course of treatment, is from four to eight months. When repeat courses of the intravenous nitrogen mustard are indicated, as a rule, the remissions become progressively shorter in time. Treatment with nitrogen mustards may be alternated with treatments of roentgen therapy, but these should not follow each other too soon, because of the added hazard to the hematopoietic system. This combined treatment may at times keep the disease under control a little longer than if either is used alone. Eventually, however, tolerance is lowered and the treatment has to be terminated. Boland recently reported a series of cases of Hodgkin's disease where the combined use of roentgen therapy and nitrogen mustards showed the average duration of life being extended about three months.

In summary, I should like to quote from Jacobsen, of the University of Chicago: "Irradiation should be continued as long as feasible in controlling local tumor masses, with nitrogen mustard as adjunctive therapy in suppressing multicentric dissemination of the disease. Nitrogen mustard cannot be recommended as the sole therapeutic agent in lymphomas."

Oral Nitrogen Mustard

These were developed and introduced in England in 1947. The two compounds

most frequently used are R 48 and R 151. In this country the drug used of this series is called TEM or tri-ethylene-melanine. It has been used at the Memorial Hospital by Burchenal, Karnofsky, et al., for Hodgkin's disease, lymphosarcoma, chronic lymphatic and myelogenous leukemia, and mycosis fungoides.

The advantages of this drug, which resembles the nitrogen mustards toxicologically and therapeutically are:

1. It rarely causes nausea and vomiting.
2. It can be given orally in convenient maintenance doses or by repeated periodic courses.

However, the oral nitrogen mustard has the very disadvantage that it was hoped it would overcome, namely: an inadequate margin between its therapeutic and toxic effects. In other words, the advantage of relatively low toxicity was counter-balanced by feeble therapeutic action.

The results of the oral nitrogen mustard therapy have generally proved disappointing because it acts more slowly, and remissions are less frequent, less complete, and of shorter duration than those induced by intravenous nitrogen mustards. Hence, it is now recommended only if the intravenous nitrogen mustard is contra-indicated for any reason.

Urethane

This substance is specifically injurious to proliferating tissues, and is a powerful depressant on leukocyte production. This drug has been used in the treatment of chronic myelogenous leukemia, but the results are no better than those obtained by radio-therapy, which is simpler and more practical. Toxic effects with the use of urethane are not uncommon, and there may be neurological changes as well.

Some observers, such as Rundles, have also claimed temporary improvement in the treatment of multiple myeloma. However, the New York Memorial Hospital group believe that if the disease is localized one should always use roentgen therapy, and that, in diffuse disease, urethane has shown no significant clinical results.

Stilbamidine

This is an organic preparation of antimony that was introduced by Snapper in 1946 for the treatment of multiple mye-

loma. Bone pain may be relieved and the general health of the patient improved. The rate of progress of the disease may be slowed down. The effects, however, are only temporary. The hyper-globulinaemia is not affected, and radiographic examination shows no improvement in the bone lesions.

Perhaps the most troublesome toxic effect of all is that produced on the trigeminal nerve. Several months after treatment has been completed, pain develops in the distribution of one or both trigeminal nerves in a high proportion of patients. In the series reported by Arai and Snapper (1946), 10 of the 18 patients treated by Stilbamidine developed this complication.

Folic Acid Antagonists

Both aminopterin and amethopterin have been used. Farber in 1948, and later Damecheck, and other workers, showed that in acute leukemia, and particularly in acute lymphatic leukemia in children, the use of anti-fols led to rapid destruction of immature cells; in some cases the bone marrow appeared to return to normal. Burchenal, et al., recently reported that 32% of children, and young adults under the age of 24, with acute lymphatic leukemia, showed definite clinical remissions; only about 3% of adults showed remissions. Although momentarily gratifying, the anti-fols are obviously not the complete answer to the problem.

Many of these patients soon became resistant to amethopterin, but still responded temporarily to cortisone, but with short remissions. A few patients regained their sensitivity to amethopterin after a remission induced by cortisone, but patients were frequently refractory to a second course of ACTH or cortisone. The action of the anti-fols is said to be the interference with the synthesis of nucleic acids, essential to cell growth and multiplication, especially in rapidly dividing tissues.

Toxic effects are the rule, such as stomatitis and gastroenteritis, and bone marrow depression with pancytopenia.

In summary, we might quote Myer of the Cornell University Hospital: "Contrary to earlier enthusiastic reports, in no instance did the anti-fols significantly improve the course of any patient. Toxic manifestations in one form or another were found in all cases."

ACTH and Cortisone

It was observed that in cases of adrenal insufficiency there was concomitant lymphoid hyperplasia; accordingly, it was thought to be rational to attempt to create a condition of relative adrenal hypercortical activity, by the administration of ACTH or cortisone. This, in turn, should depress the activity in the lymphoid tissues. After clinical therapeutic trials, it was observed that the lymphocytes dropped, and there was shrinkage of the lymphoid tissues, but at biopsy examination of the diseased areas there was little or no significant pathological change.

Farber, et al., reported that 65% of children with acute lymphatic leukemia showed good remissions, but these were short, and did not respond to a second course of therapy. However, the clinical response was dramatic during the short period of remission. The patient's temperature dropped, his appetite improved; in fact, he sometimes became euphoric. Farber also brought out the fact that anti-fols produce a more effective and longer remission than does ACTH or cortisone. Hence, he recommends the use of the anti-fols and later ACTH or cortisone, and alternation of these drugs.

In summary, ACTH and cortisone in the acute leukemias, or other lymphomas, have been encouraging because of the dramatic remissions. However, these are not long lasting, and, at most, we have an additional method of palliation. Finally, for the sake of completeness, I should like just to mention two additional substances, that are now rarely used in the treatment of lymphomas.

Radio-Active Substances

Radio-active phosphorus and sodium have been used in the treatment of various lymphomas. These have been of no real clinical benefit because there is not any isotope yet known that is selective enough to concentrate sufficient radio-active material locally in the diseased areas, and not affect the normal tissues.

Adenylic Acid

Rottino reported on the use of this substance in 1950. It is used only for intractable pruritis, whether the etiology be Hodgkin's disease or be due to no known cause. Over 50% of patients obtained relief for varying periods of time. It is recommended for use after all other

methods of treatment to relieve pruritis have failed.

Summary

What are we left with after an analysis of the unhappy situation just described? Just this:

In almost all lymphomas, because of our inability to cure the disease by any method, treatment should aim to make the life of the patient more comfortable and efficient, and the intervals between recurrences as long as possible.

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Carcinoid of the Rectum

Including a Case Report

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The term carcinoid was first used in 1907 by Oberndorfer, a German, to describe a nonmalignant tumor. Throughout the years the term has gradually come to be associated with benign neoplasms of the bowel and more commonly of the appendix. The pathologists have referred to this same entity at times as argentaffin tumors, argentaffinoma, and recently as neurocrine tumors. Carcinoid tumors appear to arise from the submucosa and invade the adjacent mucosa and muscularis. They tend to be benign but they do possess malignant potential. Metastasis usually occurs late in the course of the disease. Pearson and Fitzgerald have reported that removal of the primary focus, even with distal metastasis, has resulted in a symptom-free interval of many years.

Occurrence

Carcinoids of the rectum are relatively rare. It has been reported by Foot that approximately .46% of all appendices removed were found to contain carcinoid tumors. As far as we could find approximately eighty cases of carcinoid of the rectum have been recorded in the literature. Bacon and his associates list the incidence of metastasis of carcinoid of the rectum at approximately 10%. This is the lowest incidence of metastasis for any

group of carcinoids, except the appendiceal group.

Microscopic Picture

Microscopically, carcinoids commonly consist of densely packed masses of small cells with clear cytoplasm, having small central nuclei. They are usually arranged in cord or pseudo-rosette formation. These tumors are believed to be of endocrine origin, in the chromofin system of the mucosa. The cells of most carcinoids have a particular affinity for silver stains, but recently it has been shown that those arising in the submucosa of the rectum do not possess this characteristic. Carcinoids come into being by migration, not necessarily with mitosis, of normal body cells to the surface.

Incidence of Metastasis

Histological examination affords little basis for determination of malignant potential. It has been found that the incidence of metastasis from primary lesions in the large and small intestines is significant. These findings are in contrast to the low incidence of nodular involvement and remote metastasis with carcinoids of the appendix. The rectal variety lie intermediate, and recently, by Rosser, have been classed according to their activity. He groups them into "first, benign infiltration, as in the appendix, where it may

invade all of the coats of the bowel but halts permanently at the serosa; or, second, it may exhibit from the beginning a highly malignant metastatic tendency." It has been expressed by Raven, Pearson, and Fitzgerald that as the lesion progresses in size it is only a matter of time until it will eventually transgress its natural barriers. It would appear from reported instances that all cases falling in Rosser's Group 2 classification follow a rapid and consistently down-hill course to death. He recently reported one such case.

Up until very recently most articles concerning carcinoids of the rectum were written from the pathologist's view with very little attention being paid to therapy or prognosis. In 1951 Mayo and McKee reviewed the world literature and attempted to summarize the points of interest from a clinician's viewpoint.

Many Cases Reviewed

Certain aspects of the clinical features of the carcinoids are worthy of consideration. A survey of some 14,000 reviewed cases at the University of Pennsylvania in 1949 by Horn revealed six cases of carcinoid of the rectum. In all cases the lesions were found on rectal or proctoscopic examinations performed as a routine procedure in cases of anal fistula, fissure, hemorrhoids, etc. In a review of twenty-four cases taken from the literature, only seven had any type of symptoms probably related to carcinoid. In those seven reported cases, bleeding is probably the most important presenting symptom. Next in order of frequency was decreased caliber of the stool, followed by constipation, tenesmus and low abdominal pain. As in other types of cancer with metastasis weakness, fatigue, weight loss, etc., are encountered. The age and sex incidence is noncontributory except that patients with metastasis are usually in the fifty to seventy age group.

Gross Appearance

Grossly the appearance is a solitary, non-tender, submucosal nodule and in a few instances multiple nodules have been recorded. In fact, the nodular type of carcinoid is the most commonly encountered of the rectal lesions, but as such constitutes only about 2% of all types of rectal submucosal nodules. Jackman, of the Mayo Clinic, in 1947 studied eighty-seven individuals with such types of lesions. He found forty-seven of these nodules to be residuals following injec-

tion therapy (eleomas), twenty-six were inflammatory lesions, eight were benign neoplasms, and four were carcinoids. Naturally, biopsy studies are mandatory in arriving at an accurate diagnosis.

Incidence of Metastasis

Pearson and Fitzgerald, Mallery Carr Institute of Pathology, have studied in detail thirty-two known cases of carcinoid of the rectum and found four cases of metastasis. Two of these four were dead in less than two years. Recently, Bacon and associates have reported seven cases of carcinoid of the rectum and one of these cases was associated with metastasis. Rosser has recently reported two cases of carcinoid of the rectum in which one case was associated with widespread metastases.

Therapeutic Trend

The trend in therapy has undergone some variance recently. It would appear that solitary, movable lesions, small in caliber, located in young patients, might well be handled by wide local excision. These patients should be carefully followed at frequent intervals for local recurrence or evidence of metastasis. However, if the original lesion is annular, fixed, diffusely infiltrating, especially in patients past middle age, then extensive surgery seems to be justifiable. Abdominal-perineal resections and similar types of radical procedures have been reported by Wilson, Ashworth, Rosser and Bacon in dealing with metastatic lesions. Their results were discouraging. In those cases falling between these two extremes, then considerable clinical judgment is called for. This is especially true because as yet the number of cases has not been great nor proper assays established.

In thirty cases of local wide excisions by aggregate authors, twenty-four have been followed for from four months to nine years with no evidence of recurrence of metastasis.

As to the effective therapy by the use of irradiation, radium needles, or the use of radium active isotopes, very little work and no definite data have been recorded.

Case Report

C. M., age twenty-nine, was seen in October, 1951 with a chief complaint of rectal bleeding, bright red, off and on during the past year. His past history, general physical examination, and routine laboratory checks were noncontribu-

tory. On rectal examination he had one anterior mixed hemorrhoid of moderate size. A small non-tender, freely movable, hard, submucosal nodule, about 0.2 cm. in diameter was palpated. This nodule was about 2 cms. above the pectonate line on the left posterior area. A sigmoidoscopic examination was done, the only findings being two very small, 2x2x3 mm., mucosal polyps in the upper rectum. These, including the mucosal base, were removed with biopsy instruments, the pathology report being non-malignant adenoma. Because of the presence of the hard submucosal nodule the patient was hospitalized. This nodule was removed by wide local excision and after this the hemorrhoid was dealt with.

Pathology Report

The pathology report is summarized: Grossly the specimen measures 1 x $\frac{3}{4}$ cm. in size. The tissue is white to pink in color. In the tissue there is a hard, nodular mass which measures $\frac{3}{4}$ x $\frac{1}{2}$ cm. in size and appears to be white in color. On cut section the mass is homogeneous and appears to be hard in consistency. There is a small amount of rectal mucosa surrounding the mass.

Microscopic Examination

The tissue is made up of small cells with prominent, hyperchromatic nuclei that in some places are arranged in no particular pattern but in others are forming poor gland structures and in still other areas are arranged in naevoid-like nests. There are no columnar, mucous secreting cells present. At no point are the mucosal glands fused to the tumor. Wilder's silver stain and muci-carmin stain would indicate this lesion is a carcinoid. We would regard this lesion as a local lesion and feel that extirpation has

been complete. Pathological diagnosis: Carcinoid of the rectum.

Postoperative healing was normal and a three month check revealed no evidence of local recurrence.

Summary

Carcinoid tumors in the rectum are rare.

It is agreed that only 10% or less show malignant characteristics. Those that are malignant when discovered have a poor prognosis regardless of the type of treatment.

Those that are not malignant are best treated by wide local excision.

If one lesion is found careful search for others is indicated.

Close follow-up for recurrence is necessary.

The pathology, both gross and microscopic, and the clinical features have been reviewed.

One additional case of carcinoid of the rectum has been recorded.

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Special Articles

BLOOD PROCUREMENT IN CIVIL DEFENSE

WILLIAM M. SAVAGE, M. D.

Maysville

The very real possibility of an atomic attack upon this country places upon the medical profession an almost insurmountable problem. This problem involves the procurement of adequate supplies of whole blood, plasma, and plasma expanders in unprecedented quantities in the event of such an attack. Apathy is the normal reaction on the part of most since it is felt that such a possibility is remote, and further, that the time, money, and planning spent in such a venture may be totally wasted. However, if such is the case, we will have expended only time and effort; whereas, if this possibility becomes a reality and we are not thoroughly organized for such an emergency, we will have failed to meet our responsibilities, and the casualties will have been increased many fold through our own lethargy.

How may each of us apply our efforts toward such preparedness? Many may not be called to join mobile medical units but can help through insisting on and sponsoring a well organized local system of blood procurement which would be available on a moment's notice. Each county medical society should see that the local civil defense director has appointed a blood program director and an advisory committee. On this committee there should be a representative of the county medical society, the city or county health department, and the local Red Cross. This committee should prepare plans for the procurement of blood in large quantities through the organization of potential type O donors in the community to meet the needs during a critical emergency. These donors should be listed and their availability determined, for it is this great potential volume of blood to which we must turn for instant need. No group or town will be too small to share its responsibility for the almost limitless demand. Plans should be further instituted for drawing of this blood, for its care and delivery to distribution centers.

A conservative estimate has been made to the effect that a single atomic bomb

dropped on any of our cities during daylight hours, even with adequate air-raid warnings, would result in a minimum of sixty thousand casualties. Approximately forty thousand of this group would survive after twenty four hours and these would require during this initial period a total of one hundred twenty thousand units of blood, plasma or plasma expanders. During the first few hours, the available Federal reserves of plasma and plasma expanders would be rushed to the disaster area, to be followed shortly thereafter by the available supplies of whole blood. However, such supplies would be quickly depleted and totally inadequate for the extended treatment necessary for the later care of these patients. Further supplies of blood would then of necessity come from the local organized centers of procurement and only through thorough and adequate planning can we be ready to meet such an emergency. We must better organize our existing blood bank and donor center facilities and develop additional facilities which can become immediately effective on demand. We must remind ourselves that the answer and only hope for the thousands of casualties lie in unlimited supplies of donor blood. When we consider the fact that an attack would probably be directed toward many target areas at the same time, the demand would seem almost impossible to fulfill. However, it CAN and MUST be done.

Each individual physician then must assume the responsibility not only of joining the mobile defense units when called upon or of keeping himself in readiness to do his utmost in the event of disaster, but further insist that his own County Medical Society become aware of the need for organization of blood procurement facilities through the local committee. Only by such a program can we assure ourselves that we, the Physicians of Kentucky, have shouldered our responsibility and that we are carrying our full share of the United States Civil Defense Program.

A NOTE ON MALARIA

EMIL KOTCHER, Sc. D.

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Louisville

Public health workers and physicians have witnessed a marked recession and the virtual eradication of indigenous malaria in Kentucky in the past two decades. This decrease has been apparent in the declining figures for malaria morbidity and mortality throughout Kentucky. One area in which there prevailed a high endemicity of the disease was Western Kentucky, particularly along the Mississippi bottomland. The extreme western sector of Fulton County is typical of this area where a high anophelism (*Anopheles quadrimaculatus*) and some social and economic factors existed that were satisfactory for the transmission of the malaria plasmodia. The decline of the malaria mortality rate in Fulton County is shown in Table 1.

Table 1

Malaria Mortality Rate—Fulton Co., Ky.

Year	No. Deaths	Deaths 100,000
1925	8	53
1926	2	13
1927	2	13
—	—	—
1930	3	20
1931	1	7
1932	3	20
1933	11	73
1934	2	13
1935	11	73
1936	4	27
1937	4	27
1938	—	—
1939	5	—
1940	2	13
1941	2	13
1942	2	13
1943	4	27
1944	2	13
1945	1	7
1946	—	—
1947	2	13
1948	—	—
1949	—	—
1950	1	7

During the summer of 1936, Doctor Marjorie Rountree, the field malariologist attached to the Fulton County Health Department, made a blood film survey of school children in the county. In view of the fact that anophelism in the western

part of the county is still high and the social and economic conditions are not greatly changed since 1936, it was decided to resurvey the school children in this part of the county during the summer of 1951. The comparative data of the two surveys are presented in Table 2.

Table 2

Blood Film Survey of School Children in Fulton Co., Ky.

Place	1936			1951		
	No. Films	No. Pos.	% Pos.	No. Films	No. Pos.	% Pos.
Bottomland, White	229	4	1.7	360	0	0
Bottomland, Colored	84	2	2.3	175	0	0
Madrid Bend, (July 1936 White)	26	3	11.5	40	0	0
Madrid Bend, White (Nov. 1936)	25	2	8.0	—	—	—

The negative findings of the 1951 survey bear out what has been observed in late years, namely, the virtual absence of malaria in this area. The factors that have brought about this marked reduction (and probably eradication) of malaria are difficult to assess. Many homes in this area have been treated with DDT. Many of the inhabitants have received antimalarial therapy, some receiving quinine and others quinacrine (atabrine). The diet of these people has very likely improved though specific comparative data are lacking.

Some of the older practicing physicians believe there is still a considerable amount of malaria. Their beliefs are based almost entirely on clinical findings. The younger physicians are less prone to make a diagnosis of malaria without laboratory confirmation. The U. S. Public Health Service and the State Department of Health are anxious to have all cases of malaria reported to it. It is desired, however, to have these reported cases confirmed by laboratory examination of blood smears before antimalarial therapy has been given. It has been shown that blood smears will be positive in 90% of the patients suffering with malaria.

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DIABETES DETECTION AND EDUCATION DRIVE AN IMPORTANT PUBLIC SERVICE

For the second straight year, the Kentucky State Medical Association will co-operate with the American Diabetes Association in sponsoring the annual drive on Diabetes Detection and Education. In this commonwealth the drive will be sponsored by the co-operating County Medical Societies through their diabetes committees, with the support of the State Committee on Diabetes.

The drive is a non-fund raising, educational, and case-finding program, which is unique in that it is channeled exclusively through the medical profession. During the week of November 16 to 22, all physicians in Kentucky are asked to take part in this most worthy and unusual program of public service.

Your Committee on Diabetes wishes to commend and thank the physicians of Kentucky who co-operated in this effort in 1951. Your good work last year attracted the attention of the American Diabetes Association and produced much favorable comment. The committee feels that with the experience gained from the initial venture our state this year will render an even more valuable service to our patients.

The importance of early detection of diabetes in our patients, as all our members know, cannot be overestimated. Through this one-week program of detection and education, each of us has an opportunity of rendering a service of untold value to the public at small cost of time to us and without charge to the patient, which will enable the patient to live a

long, useful life. It is not difficult to imagine the degree of appreciation felt by the individuals and their families in the nearly 100 diabetic cases detected in this state through our drive last year.

In these days when some authorities in our government, many of whose employees' social philosophies are of a doubtful hue, try to convince the public that the rank and file of the medical profession is composed of money-grabbing monsters, our committee feels that the thinking members of our profession will be glad to demonstrate once more that the heart of the average physician is in the right place and that this opportunity to render an unselfish service will be embraced.

The search for the one million unknown diabetics in our population is and must continue to be unremitting and intensive, until it becomes accepted practice for every one to have a regular health examination and a simple screening test for diabetes.

Your Committee on Diabetes recommends and warmly urges you to participate actively in the November 16 to 22 drive this year. Your committee feels that it is not only the best interests of the public to give active support to this campaign, to which a large number of statewide organizations have given their unqualified endorsement, but also to the profession itself.

CARLISLE MORSE, M. D., Chairman
Committee on Diabetes.

PHYSICIANS PARTICIPATE IN DRAFTING THE CODE OF PROFESSIONAL CONDUCT

Thoreau said "That government is best which governs least." While we agree with him in principle, we believe it would have been more accurate to have said "That government is best which governs no more than is necessary." Perhaps we are splitting hairs since the trend in government today is certainly not in the direction of under-governing. For the good of society, government, and governmental

regulation, is, of course, necessary. It is not always easy, however, to determine the dividing line between beneficial regulation and the beginning of regimentation.

Although governmental regulation of the medical profession is anathema to many physicians, we doubt if those physicians would be content to practice under conditions that would result from a com-

plete lack of governmental control. For the protection of the people and of the profession itself it is necessary that government prohibit the practice of medicine by unlicensed persons. It is also right and proper for government to establish the standards to be met to be eligible for a license to practice, and to take away professional rights and privileges when persons prove to be unworthy of them. Without the yardstick of eligibility standards to measure the qualifications of persons desiring to practice there could not even be a medical profession. Any quack with a shingle could open an office and be in business.

In order to protect itself, however, it is essential that any governed group participate in the formulation of the laws and regulations that affect it. Too frequently this safeguard of democracy is neglected. We are glad to say that this has not been the case in the enactment of the Medical and Osteopathic Practice Act of 1952 nor in the drafting of the Code of Professional Conduct which was adopted by regulation of the State Board of Health on September 4, 1952. The Kentucky State Medical Association participated in drafting the act itself since it was, on numerous occasions, presented by the State Board of Health to the Council and to the Legislative Committee for their study and suggestion. The final draft was approved by both groups.

In accordance with the provisions of the Act the Code of Professional Conduct was adopted by the Board only after it held a hearing on a proposed code which the Board had formulated and furnished to each licentiate. We think it was a compliment to the profession that it was so well represented at the hearing. Those present entered freely into the discussion of the provisions that should be included and those that should not. At the meeting were the President, President-Elect, Chairman of the Council, members of the Council, other officers and a goodly number of members of the Association. Agreement was reached, and following the hearing the State Board of Health adopted the following Code of Professional Conduct, which was approved by the Executive Committee of the Council:

"ARTICLE I

No person licensed to practice medicine or osteopathy shall advertise or permit his or her services to be advertised. Provided, that such

person may publish a brief announcement, by advertisement, cards or letters, of the opening of an office and of any change of office location or changes of office hours, and may cause to be listed in telephone directories, and classified advertising sections thereof, his or her name, address, type of practice and office hours. Modest signs on the doors, windows and walls of the licensee's office, or on the building in which he or she maintains an office, setting out his or her name and title, and location shall not be considered objectionable.

"ARTICLE II

No person licensed to practice medicine or osteopathy shall represent that he or she can effect radical cures by secret treatments, or by other secret remedial agents, or by methods not generally recognized, approved and employed by his profession.

"ARTICLE III

No person licensed to practice medicine or osteopathy shall dispose of his professional attainments or services to any corporation, hospital, lay body, lay organization, lay group or lay individual, by whatever name called, or however organized, under terms or conditions which permit exploitation of the services of the physician for the financial profit of the agency concerned."

The democratic process did not stop with the adoption and filing of the Code with the Statutes Revision Commission. The Act provides an additional thirty days in which any licentiate who may be aggrieved by it has a legal right to challenge it.

Each article in the Code was taken from or based on a similar section of the American Medical Association's Code of Ethics. Articles I and II provide the means of controlling situations that in the past have been most embarrassing to the profession and detrimental to the public, but about which nothing could be done other than to exclude the offender from medical society membership. Article III provides the means of controlling one of the greatest menaces to the profession: the corporate practice of medicine. So far as we know there are only two ways that a corporation can practice medicine. One is by rendering medical services by laymen, which constitutes the unlicensed practice of medicine, and the other, which is a more serious threat, is through the provision of medical services by physicians who are either employees of the corporation or have entered into some sort

(Continued on page 453)

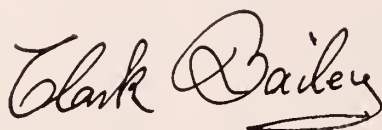
President's Page

Through the past year it has been my privilege to attend and participate in many medical meetings over the entire state of Kentucky. To meet with the various committees of the Association and observe the sincerity with which they approach the task assigned is most encouraging. The working in unity under the direction of the officers and the Council can result only in remarkable achievement in our growth as a profession. Our working together toward solving the relative and integral problems of medicine brings to each member of the Association an enlightenment as to the purpose, responsibility, and need of our organization.

The result of our striving together will be determined by whether or not we shall succeed in keeping ourselves free from

the shackles of socialism so that we might improve our service to mankind and offer that service in a spirit of freedom without domination or threat. That is the heart of the matter. It has a very dear concern for both you and me.

During the past year not one single request of participation in the activities of the Association has been refused by any member. Our achievements have been great due to the willingness of each member to do his or her part. My gratitude as your retiring president for your most gracious co-operation cannot be expressed. May I insist that you give to your new president the same loyalty and support as we strive together in the continuing growth and progress of our Association.

A handwritten signature in cursive script that reads "Clark Bailey". The signature is written in dark ink and has a fluid, elegant style with a long horizontal flourish at the end.

PRESIDENT

ORGANIZATION SECTION

KSMA Pushes Diabetes Detection Drive, Nov. 16-22

Members of the Kentucky State Medical Association will again participate in the annual drive November 16 to 22, designed to locate its share of the estimated one million diabetics and to detect a portion of the two million-odd potential diabetics in the country, Carlisle Morse, M. D., Louisville, Chairman of the K. S. M. A. Committee on Diabetes, announced.

The Annual Diabetes Detection and Education Drive will be promoted at the county level and will be under the direction of the Diabetes Committees of the County Medical Societies. Most of the active county medical societies have submitted their committees to the headquarters office of the Association, and Doctor Morse urges those who have not to submit them as soon as possible.

This is the second time the Association has participated in the non-fund-raising and educational effort. Last year in Kentucky, according to Dr. Morse, nearly one hundred diabetics were detected and some 225 were diagnosed as potential diabetics. The initial Kentucky effort last year attracted considerable praise from the American Diabetes Association, a physician-sponsored and controlled organization.

The Annual Drive has the support of Clark Bailey, M. D., Harlan, President of the Association, who asked the County Medical Societies to appoint committees and co-operate, as well as the backing of the Council. Plans were laid early in the year by the State Committee for the program this fall when national officials of the American Diabetic Association attended the committee meeting in Louisville.

During the 1952 Annual Meeting, Arthur Colwell, M. D., professor of the Northwestern University School of Medicine and nationally recognized internist, appeared several times on radio and television in behalf of the drive. Dr. Colwell was one of the guest scientific essayists.

Approximately a dozen state-wide lay and professional organizations have endorsed the 1952 Diabetic Detection and Education Drive, Dr. Morse said. Many organizations commended the Association in this public service effort and offered their active support.

Other members of the K.S.M.A. Committee on Diabetes are: Luther Bach, M. D., Newport, Herald K. Bailey, M. D., Ashland, George N.

Burger, M. D., Covington, Guinn S. Cost, M.D., Hopkinsville, William P. Hall, M. D., Paducah, Frank H. Moore, M. D., Bowling Green, Franklin B. Moosnick, M. D., Lexington, and William R. Parks, M. D., Harlan.

Southern Medical Association to Meet in Miami, November 10-13

The Forty Sixth Annual Meeting of the Southern Medical Association will be held in the Library and Municipal Auditorium, Bayfront Park, Miami, Florida, November 10 to 13.

J. R. Wilkinson, M. D., Huntington, West Virginia, is president. Edward W. Cullipher, M. D., Miami, is the general chairman of arrangements. A. Clayton McCarty, M. D., Louisville, is Councilor for Kentucky. A number of Kentucky State Medical Association members will participate in the Southern scientific program.

The Woman's Auxiliary to the S.M.A. will also hold its annual meeting November 10 to 13. Wives of all physicians attending the S.M.A. were urged by the Auxiliary president, Mrs. V. Eugene Holcombe, Charleston, West Virginia, to attend Auxiliary meetings.

Many Kentucky physicians' wives have been active in the S.M.A. Auxiliary, said Mrs. Holcombe. Mrs. Luther Bach, Lexington, Mrs. Shelby Carr, Richmond, and Mrs. A. T. McCormack, Louisville, are on the Executive Board, and Mrs. J. A. Ryan, Covington, is councilor from Kentucky.

Dates And Plans For 1953 Series of Telephone Seminars Set

Telephone Seminars will be held January 27, February 24, March 24, and April 28, during the coming year, Robert Lich, M. D., Louisville, Chairman of the Kentucky State Medical Association Committee on Medical Education announced following the meeting of his committee on September 12.

This will be the second year this program of post graduate education, sponsored by the Kentucky State Medical Association in co-operation with the University of Louisville School of Medicine has been held, Dr. Lich said. This year three Telephone Seminars were held, and, according to Dr. Lich, the response was so favorable a second series of programs were authorized by the Council.

While panelists and specific subjects will be announced at a later date, material covering the general subjects will be presented as follows: For the January session the discussion will cover Abdominal Emergencies; February, The Significance of Cough; March, Proctology; and April, Ophthalmology in General Practice will be covered.

It was pointed out by the Chairman that the Committee felt on the basis of experience gained in the first series of seminars, it would be possible to make the second series more interesting and profitable to the subscribing county medical societies. One of the innovations planned for the 1953 Seminar will include sending ten lantern slides—some of which will be in color—to each listening center. The plan is to project these slides as a visual aid at the proper time during the course of the lectures, in addition to material presented in the manuals.

For the last one of the 1952 Seminars a total of 28 county medical societies were receiving the program. It was estimated that the largest audience of physicians to hear a scientific program in Kentucky heard the seminars. Dr. Lich expressed the Committee's sincere appreciation to the Medical School for the important role it played in the 1952 series of programs.

Other members of the Committee on Medical Education are: Herbert L. Clay, Jr., M.D., J. R. Gott, M. D., and Lawrence T. Minish, M.D., of Louisville; O. T. Davis, M. D., Owensboro; D. G. Miller, Jr., M. D., Morgantown; and Frederick A. Scott, M. D., Madisonville.

Membership-Exhibitor Cooperation Praised by Committee

The growing spirit of cooperation between the membership and technical exhibitors at the Annual Meetings is one of the strongest factors in contributing to the goal of establishing the K.S.M.A. Annual Session as one of the best among the smaller State Associations, believes Carlisle R. Petty, M. D., Chairman of the Committee on Technical Exhibits.

"Without the support of the technical exhibitors, we do not have the funds to develop a top-flight high-calibre scientific program. And, unless the membership supports the exhibitors, we cannot hope to attract these fine companies, who through rentals paid for booth space, finance our meeting," Dr. Petty said.

"The Committee on Technical Exhibits wants to express its sincere appreciation to both the membership and the exhibitors for their splendid support," the Chairman stated. The 60 technical exhibitors at the 1952 Meeting were:

Abbott Laboratories
A. S. Aloe Company
Ames and Company
Ayerst, McKenna & Harrison, Ltd.
Bilhuber-Knoll Corporation
Blue Cross-Blue Shield
The Borden Company
Burroughs Wellcome & Company, Inc.
Camel Cigarettes
Campbell Associates
Central Dairy Council
Central Pharmacal Company
Ciba Pharmaceutical Products, Inc.
The Coca-Cola Company
The Dick X-Ray Company
Doak's Surgical Supplies
Doho Chemical Corporation
H. G. Fischer and Company
C. B. Fleet Company, Inc.
General Electric Company
Guild of Prescription Opticians of Kentucky, Inc.
John Hancock Mutual Life Insurance Company
Hoffman-LaRoche, Inc.
Kay Surgical, Incorporated
The Lanier Company
Lanteen Medical Laboratories, Inc.
Lederle Laboratories
Eli Lilly & Company
Louisville Surgical Supply Company
J. A. Majors Company
S. E. Massengill Company
McNeil Laboratories, Inc.
Mead Johnson & Company
Medical Protective Company
The William S. Merrell Company
The C. V. Mosby Company
M & R Dietetic Laboratories, Inc.
National Drug Company
Ortho Pharmaceutical Corporation
Parke, Davis and Company
Charles Pfizer & Company, Inc.
Philip Morris and Company, Ltd., Inc.
A. H. Robins Company, Inc.
Sandoz Pharmaceuticals, Inc.
Schering Corporation
Sealy Mattress Company
G. D. Searle & Company
Sharp & Dohme, Inc.
Smith, Kline & French Laboratories
E. R. Squibb and Sons
Theodore Tafel
The Upjohn Company
Templar-Thelan X-Ray Company
Tru-Fit Surgical Appliance Company
Van Pelt & Brown, Inc.
U. S. Vitamin Corporation
Winthrop-Stearns, Inc.
The Max Woche & Son Company
Wyeth, Incorporated

Dr. Lamb Joins State Department

William F. Lamb, M. D., formerly deputy director of health of the Louisville-Jefferson County Board of Health, became associated with the State Department of Health as of September 2.

A native of Franklin, Ky., Dr. Lamb graduated from the Northwestern University School of Medicine in 1929. He has the title of Deputy Commissioner of Health in Charge of General Health Services.

Ten From KSMA Attend Charleston Medical Care Conference

Ten members of the Kentucky State Medical Association attended the American Medical Association-sponsored Charleston Conference on Medical Care in the bituminous coal-mining area, September 6 and 7, to which were invited representatives from Kentucky, Pennsylvania, Tennessee, Virginia, and West Virginia.

Carl Fortune, M.D., Lexington, chairman of the Advisory Committee to the United Mine Workers of America Welfare and Retirement Fund, and Clark Bailey, M.D., Harlan, then president of the Association, led the Kentucky delegation to the meeting, the purpose of which was to study medical and hospital care problems in the mining areas.

W. A. Sawyer, M.D., chairman of the A.M.A. Committee on Medical Care for Industrial Workers, presided at the meeting. Other leading figures present were Elmer Hess, M.D., chairman of the A.M.A. Council on Medical Service, A. J. Lanza, M.D., chairman of the A.M.A. Council on Medical Service, and Warren Draper, M.D., executive medical officer of the U.M.W.A.

Clyde C. Sparks, M.D., Ashland, chairman of the Council, R. Haynes Barr, M.D., Owensboro, then President-Elect, Bruce Underwood, M.D., Louisville, secretary and general manager, and Duffy Hancock, M.D., Louisville, A.M.A. delegate, were among other K.S.M.A. officials present, along with George F. Brockman, M.D., Greenville, Robert S. Howard, M.D., Harlan, and C. Dana Synder, M.D., Hazard, who are members of the Advisory Committee. Walter S. Coe, M.D., represented the University of Louisville School of Medicine.

Asa Barnes, M.D., Louisville, William H. Riheldoffer, M.D., Huntington, West Virginia, and John Winebrenner, M.D., Knoxville, U.M.W.A. Area Medical Directors for this state, were in attendance.

At the close of the meeting, attendants expressed themselves as well pleased with progress made at the meeting, and it was voted to make it an annual affair.

P-R Head, U of L Dean Address National Bureau Group

Leo Brown, Public Relations Director of the American Medical Association, and J. Murray Kinsman, M. D., Dean of the University of Louisville School of Medicine, shared the spotlight on the program of the National Association of Medical and Dental Bureaus at its three-day meeting in Louisville, September 17 to 19.

"P-R Profits" was the subject Mr. Brown discussed before the more than 100 representatives of 81 bureaus throughout the country. He elaborated on the theme of conducting the operations of the business with the view of deriving public relations as well as dollar profits.

"Public Relations" was the subject of Dean Kinsman's address. The Dean pointed out there were two important aspects to the public relations of any organization. One was the organization as a whole, and the other was that of the individual unit of the organization. He stressed the need of the individual unit in any group conducting his business in such a way as to contribute not only to his own public relations, but to that of the group as well.

Both Mr. Brown and Dean Kinsman commended the representatives on the excellent grasp they had on public relations problems and their efforts to improve doctor-patient relationships.

Facilities for Medical Education Reported Rapidly Expanding

There were 6,080 graduates from the 72 medical schools and seven basic science schools this year, as facilities for medical education in the United States reached an all time high, according to the fifty-second annual report on medical education prepared by the A.M.A. Council on Medical Education and hospitals.

The Council states there has been an unprecedented increase in medical school plants since World War II and that medical schools are receiving better financial support than at any other time in their history. The Council says additional expansion in the years ahead is indicated, unless war or depression influences present plans.

Last year medical school enrollment increased 3.4 per cent, and the size of the freshman class increase 3.6 per cent over the previous year. The first year enrollment is now averaging better than 25 per cent more than it did before World War II.

Of last year's enrollment, 11,436 were veterans, which is a decrease in veteran enrollment of 13.2 per cent as compared with the previous

year. For the fifth consecutive year, the report states, the number of women medical students has declined. Last year the percentage of women graduates was 5.7 per cent. The all time high was 12.1 per cent. Operating funds for medical schools were increased the past year from 109 million to 120 million.

The report was made by Donald G. Anderson, M. D., Secretary to the Council on Medical Education and Hospitals of the A.M.A., and his associates, Francis R. Manlove, M. D., and Mrs. Anne Tipner.

AMA Chief to Attend WMA Session in Athens on Honeymoon

George F. Lull, M.D., Secretary and General Manager of the American Medical Association, and Miss Mildred Louise Beckman of the Council on Medical Service of the A.M.A. were married at the bride's home in Fremont, Nebraska, September 10.

Dr. and Mrs. Lull left immediately for Athens, Greece, where he will attend the annual meeting of the World Medical Association in October. They are expected to return to Chicago late in the month.

Represents KSMA at Institute

W. Vinson Pierce, M. D., Covington, Chairman of the Education Campaign Committee, represented the Kentucky State Medical Association at the Medical Public Relations Institute in Chicago, sponsored by the American Medical Association, September 4 and 5, at the Edgewater Beach Hotel.

More than 200 representatives from 41 states and several foreign countries attended the meeting, built around five panel discussions treating the most important phases of the physician's various relationships. The discussions were described by Dr. Pierce as most interesting and worthwhile.

Statement on Indigent Care Cited By KSMA Committeeman

As various officers and groups of the Kentucky State Medical Association manifest increasing interest in the solving of the indigent care problem in Kentucky, Gaithel L. Simpson, M. D., Greenville, Chairman of the Committee on Medical Service, calls attention to recent statements released by the Committee on Indigent Care of the A.M.A.'s Council on Medical Service.

The A.M.A. group's statement points out that indigent medical care plans should provide all

the services which normally are available locally to other citizens and should make equal services available to all indigent persons—the blind, old age pensioners and dependent children. In addition, the committee feels that such a plan should provide for medical supervision, and where possible offer a free choice of physician for both home and office care.

The A.M.A. group believes "that medical care for the indigent is a local problem requiring the wholehearted cooperation and participation of local physicians. Such plans should be administered locally regardless of the source of funds."

AMA Clinical Session to Meet In Denver December 2-5

The sixth Annual Clinical Sessions of the American Medical Association will be held at Denver, December 2 to 5, 1952.

Emphasis of the scientific sessions will be on diagnosis and treatment and will feature practical demonstrations on various phases of medicine of special value to the general practitioner.

In addition to scientific papers presented by leading physicians from over the United States, there will be 60 scientific exhibits of special interest to the general practitioner, a large technical exhibit, and surgical and clinical demonstration on color television.

The meeting will be held in Denver's recently enlarged Municipal Auditorium. J. Duffy Hancock, M. D., and Bruce Underwood, M.D., both of Louisville, will represent the Kentucky State Medical Association in the House of Delegates.

Freshmen Medical Students Hear Local SAMA President

Members of the freshman class at the University of Louisville School of Medicine heard the president of the University of Louisville Chapter of the Student American Medical Association, Peter A. Overstreet, Louisville, a senior at the school, tell of the advantages of joining the S.A.M.A., at a special meeting September 12, in the amphitheater at the General Hospital.

"Among the various advantages inherent in belonging to the S.A.M.A.," said Mr. Overstreet, "aside from receiving the excellent journal it publishes, is the actual and real connection with the American Medical Association itself."

It was pointed out that this relationship and the fact that nearly all medical students will belong to the S.A.M.A. make one realize that

he has a common bond with medical men throughout the country.

"As members of the S.A.M.A.," the freshmen were told, "We are entering on the ground floor through the front door into the very heart of our life work. It is said and should be an honor to become affiliated with medical men all over the country and the world."

New KSMA Members Welcomed

The Association is pleased to welcome the following new members:

Bell—Buell B. Mills, Pineville.

Calloway—C. C. Lowry and Kenneth G. Ross, Murray.

Casey—D. E. Coolahan and George Sweeney, Liberty.

Cumberland—William F. Boyer, Burkesville.

Estil—O. C. Amstutz, Irvine.

Fayette—Samuel C. Capps, Ballard Cassady (resident), David A. Hull (resident), Joe E. Lane (resident), W. K. Massie, and Charles Roach (resident), all of Lexington.

Hardin—Presley F. Martin, Elizabethtown.

Jefferson—Philip D. Briggs, Louisville.

Warren—Paul E. Goode and Harold Keen, Bowling Green.

(Continued from page 447)

of contractual arrangement whereby profit from the services of the physician accrue to the corporation. Article III of the Code would permit the suspension, probation or revocation of the license of any physician who participated in such an arrangement.

We feel that the fact that there is such a Code will act as a deterrent to some physicians who might otherwise engage in some of the prohibited activities. We do not believe that it will ever adversely affect more than an infinitesimal fraction of the physicians in our state since the vast majority would not stoop to such conduct. Without the cooperation of the profession with the State Board of Health whose duty it is to enforce it, the Code will not accomplish much, if anything. Since the profession has had a large part in drafting the Code, it is our hope and belief that such cooperation will be forthcoming when it becomes necessary to prosecute a physician who has flagrantly violated the Code of Professional Conduct and whose actions are dangerous alike to the profession and to the people.

Pertinent Paragraphs

Hart H. Hagan, W. D., announces his association with his son, William H. Hagan, M. D., in practice limited to general surgery. William H. Hagan, M. D., has just completed two years training at the University of Pennsylvania Hospital. He graduated from Harvard in 1945, and, following his internship and a tour of duty in the Armed Forces, he returned to this country to complete his requirements for Board certification.

Six Fulton county physicians are enrolled in the postgraduate course in internal medicine and circulatory diseases arranged by the Obion county (Tennessee) Medical Society in co-operation with the post graduate education committee of the Tennessee State Medical Association. They are Drs. Glenn F. Bushart, Robert W. Bushart, James C. Hancock, David L. Jones, Jean A. Poe, all of Fulton, and John G. Samuels, Jr., Hickman. Dr. John Foley Dee, of Springfield, Massachusetts, is the instructor.

Delegates to the recent American Legion convention in New York adopted a resolution opposing International Labor Organization procedures that would socialize medicine by international treaty. Another resolution mandating the Legion to urge the Veterans Administration to give special recognition to chiropractors was rejected, as was a similar resolution for optometry. Permitting veterans to choose chiropractic treatment at government expense, this resolution was defeated despite the backing of eight states with Illinois, New York, Pennsylvania, and Texas voting solidly in its favor.

Charity Hospital of Louisiana, New Orleans, in cooperation with Louisiana State University School of Medicine and Tulane University School of Medicine is offering a post-graduate course on the Premature Infant, November 5-19, 1952. This course is open to all physicians and registration will be limited to 10. For further information write Elaine Allen, M. D., Premature Infant Center, Charity Hospital, New Orleans, Louisiana.

The Medical Society of North Carolina will hold its 5th Annual Rural Health Conference on Wednesday, October 15, 1952, at the Sir Walter Hotel in Raleigh, North Carolina. Registration will begin at 9 A. M., with the program starting at 10:00. Morning, afternoon, and evening sessions are being planned.

The Washington office and the Legislative Committee of the American Medical Association are planning a group of regional meetings over the country to be held between November 15 and December 5 to study legislative problems. Representatives from the various states will attend the regional meetings for a discussion of policy approach on legislative matters, technique for introduction of bills, and an analysis of various bills.

Charged with making local arrangements for the June 1 to 5 Annual Meeting of the American Medical Association in New York City is former N. Y. State Medical Association president, J. Stanley Kenny, M. D., who has been named by the A.M.A. Board of Trustees as chairman.

The Council on Industrial Health and the Bureau of Health Education of the American Medical Association have prepared a vest-pocket size first aid manual. The Council developed this manual as a means of projecting the fact that first aid training is an essential means of promoting health and safety education as well as of saving life. Its size will encourage individuals to carry it on their person where it will be readily available for emergency use, according to J. F. McCahan, M. D., Assistant Secretary to the Council. Single copies of the manual are available without charge through the Council on Industrial Health. Quantity prices will be supplied upon request by the Order Department.

According to Ernest E. Howard, M. D., who is writing the A.M.A. Secretary's letter while George Lull, M. D., Secretary and General Manager, is honeymooning in Greece, there have been no applicants as of September 17, for the \$50,000 a year position recently advertised in newspapers under the head, "Physician to Royalty." The Woodard Medical Personnel Bureau, Chicago, will not divulge the name of the country which would like to employ the husband-wife physician team. It is known, however, that the climate is very hot and that water is very scarce—so scarce, in fact, the agency says, that the members of His Majesty's harem bathe in perfume instead of water.

The American Urological Association is offering an annual award of \$1000.00 (first prize of \$500.00, second of \$300.00 and third of \$200.00) for essays on the result of some clinical or laboratory research in Urology. Competition will be limited to urologists who have been

in such specific practice for not more than five years and to men in training to become urologists. Further information may be obtained by writing Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland.

The Annual Convention of the Association of Military Surgeons will be held at Washington, D. C., November 17-19, 1952. Reservists in the Air Force Medical Service will be granted point credits for each day's attendance at the convention, Lieut. Col. V. G. Fay, Air Surgeon of the First Air Force, Mitchell Air Force Base, New York, has announced.

September is the healthiest month of the year, judging from the way life insurance death claims are distributed across the calendar, but, according to the Institute of Life Insurance, it was formerly one of the worst months. A century ago it stood second from the top in the record of most deaths per month.

Norman H. Topping, M. D., associate director of the National Institute of Health at Bethesda, Maryland, has been appointed vice president of the University of Pennsylvania in charge of medical affairs. He is noted for his work with Rocky Mountain spotted fever and won the Typhus Commission medal.

Physicians are urged to join the Student American Medical Association as honorary members. Fee for this annual membership is \$5.00 a year and entitles the holder to an annual subscription to the 72-page monthly S.A.M.A.

The Formula for the distribution of Federal Funds for hospital construction under the Hill-Burton Act is being revised because of population and income changes, the Washington office of the A.M.A. reports. The new schedule will become effective July 1, 1953, and will continue through June, 1955. For the current year, 75 million dollars is available for new commitments, which is 7.2 million less than the last fiscal year.

Appointment was recently made of Charles D. Yohe, M. D., as clinical director of Kentucky State hospital. The post was vacant for some time.

Dr. Yohe was a member of the staff of the Central State hospital at Lakeland. He recently passed the examination for psychiatrists given by the American Board of Psychiatry and Neurology.

County Society Reports

BELL

The Bell County Medical Society held its regular meeting July 11, 1952, in the Coca-Cola Club Room in Middlesboro. Members present were Drs. Waller Griffing, Percy Zanger, C. B. Stacey, Ed Wilson, Sr., Ed Wilson, Jr., Ralph Alford, R. F. Porter, J. C. Ausmus, S. H. Flowers, and C. S. Scott. Guests were Drs. Queener and Langley and Mr. Ed Smith of Fonde.

The minutes of the last meeting were read and approved.

The program for the evening was conducted by S. H. Flowers, M. D.

Charles S. Scott, M. D., Secretary.

BELL

The regular meeting of the Bell County Medical Society was held August 8, 1952, in the new Health Department Building in Pineville. Members present were: Drs. Ed Wilson, Sr., Ed Wilson, Jr., George Bolls, S. H. Flowers, Waller Griffing, James Golden, E. W. Shaeffer, C. B. Stacey, C. S. Scott, J. S. Parrott, and Ralph Alford. Guests present were Drs. Buell Mills, R. F. Queener and Langley and Mr. Edward Smith of the Bell County Health Department.

The minutes of the last meeting were read and approved.

Waller Griffing, M. D., and Percy Zanger, M. D., were elected as Vice-President and Secretary-Treasurer, respectively, to fill vacancies left by Fred B. Weller, M. D., and C. S. Scott, M. D., who have returned to military service.

The motion was made by S. H. Flowers, M. D., duly seconded, and carried that these men fill out the remaining term of office and that they serve the full term in 1953.

A discussion was held concerning drug stores in the county which sell prescription items "over the counter." Ed Wilson, Sr., M. D., George Bolls, M. D., and Mr. Ed Smith were appointed as a committee to consider policies whereby all drug stores would comply with the federal regulations and were asked to bring their recommendations before the society at its next meeting.

The program for the evening was conducted by George Bolls, M. D.

Charles S. Scott, M. D., Secretary.

BOURBON

The Bourbon County Medical Society held its regular monthly meeting on August 6, in the library of the Bourbon County Hospital. Fourteen members and guests were present.

The Society met with Dr. Condict Moore who was here in charge of the Cancer Mobile Unit. Discussions were lead by Drs. Condict Moore and Andrew Moore, Coleman C. Johnston, and Ullen Leavell, of Lexington.

The Scientific Program was presented by Coleman Johnston, M. D., Ullen Leavell, M.D., and Andrew Moore, M. D.

B. N. Pittenger, M. D., Secretary.

HARDIN

The Hardin County Medical Society held its regular July meeting on July 1, 1952, in the Joplin Hotel, Elizabethtown, Kentucky. The meeting was a dinner for the purpose of honoring physicians in Hardin County who had been in practice fifty years or longer.

Honored guests were: E. W. Montgomery, M. D., Vine Grove; John M. English, M. D., Elizabethtown; H. R. Nusz, M. D., Elizabethtown; and John F. Glasscock, M. D., Sonora.

Special guests were: Mrs. J. C. Mobley, Mrs. M. S. Allen, and Mrs. R. T. Layman, Elizabethtown, widows of Hardin County Medical Society Members.

Invited guests were: A. D. Wilmoth, M. D., Guy Aud, M. D., Michael Casper, M. D., and E. L. Henderson, M. D., Louisville.

Others present were: Dr. and Mrs. Presley F. Martin, Dr. and Mrs. William H. Barnard, Dr. and Mrs. George Bradley, Dr. and Mrs. E. K. Hand, Dr. and Mrs. E. E. Johnston, C. F. Long, M. D., E. H. Miller, M. D., Dr. and Mrs. D. T. Roberts, Dr. and Mrs. R. T. Routt, Dr. and Mrs. E. I. Rustin, R. O. Joplin, M. D., J. S. Ray, M. D., Robert Casper, M. D., John Casey, M. D., Dr. Blair, Judge W. S. Long, Mr. and Mrs. Harold Boyd, Mrs. Margaret Montgomery, Mrs. H. R. Nusz, Mrs. Margaret Mantel Losson and Miss Aud, sister of Dr. Guy Aud.

C. F. Long, M. D., was master of ceremony. He introduced honored guests, special guests and invited guests. Each of the honored guests made a few remarks concerning their fifty years practice. Short addresses were made by Drs. Wilmoth, Aud, and Michael Casper, honoring and commemorating those physicians having completed fifty years in the practice of Medicine.

Mrs. J. S. Hawkins, local music teacher, and four young ladies were present for a few enjoyable songs.

Louis Songster, a local boy, entertained the group with his magician act.

William H. Barnard, M. D., Secretary.

JEFFERSON

At the meeting of the Jefferson County Medical Society on May 19, 1952, at the Seelbach hotel, 52 members were present for dinner and ten additional for the business and scientific sessions.

The meeting was called to order by R. R. Slucher, M. D., President, and the minutes of the previous meeting were read and approved.

J. Murray Kinsman, M. D., Chairman of the Executive Committee, stated that no definite action had been taken on the recommendation of Dr. Lytle Atherton that hospital staff meetings be consolidated; however, he had consulted various persons, and a report would be made later.

The Executive Committee considered the request from the Fetal and Maternal Mortality Committee that the County Society pay the salary of a stenographer to handle the committee's clerical work. Dr. Kinsman moved that as the Society is not justified in granting this request an effort should be made to obtain funds for this purpose from the State Board of Health or some other agency. The motion was seconded and carried.

Robertson O. Joplin, M. D., stated that the Medical Liaison Committee had met with a similar committee appointed by the Louisville Bar Association and that the lawyers wish to have a joint meeting with the County Society in order to work out a better co-operative policy between the two groups.

Dr. Slucher endorsed this plan and asked for discussion. Dr. Kinsman moved, and the motion carried, that there be a joint meeting of the Louisville Bar Association and the Jefferson County Medical Society.

It was further agreed that the regular June meeting be set aside for this purpose.

Samuel Anderson, Chairman of the School Health Committee, stated that school children in the county are required to have three physical examinations during their grade and high school career and that in the past the Health Department has taken the responsibility for these examinations, hiring physicians for this purpose. The School Health Committee felt it would be good public relations for private physicians to accept this responsibility and set a standard fee of \$2.00 for each examination, and that indigent patients be examined free. Such a motion was then made and carried after a discussion.

The Necrology Committee's report on the death of Albert L. Eddy, M. D., was read by the Secretary.

The Secretary also read the following:

A request from the A.M.A. that members pay their 1592 dues at once so they can register at the annual meeting.

A letter from the Kentucky State Medical Association calling attention to the special rate of \$5.00 offered residents and interns who are graduates of recognized medical schools and practicing in Kentucky, to become members of the state association, contingent upon the co-operation of the County Society.

Albert Goldin, M.D., was elected to membership.

The following were approved for Emeritus membership: C. C. DeWitt, M. D., Gavin Fulton, M. D., and F. L. Peddicord, M. D.

Dr. Slucher suggested that in order to insure a large attendance at the June joint meeting with lawyers a special letter be sent to all members of the Society. It was moved by Dr. Joplin that members be notified by letter. Dr. Wallace Frank moved to amend the motion by sending the notice with the bulletin to save postage. The motion as amended was carried.

E. L. Shiflett, M. D., referred to Dr. Kinsman's remarks about consolidating hospital staff meetings and suggested that the Society instruct their delegates to the A.M.A. to present this question to the House of Delegates in order to ascertain the feeling toward such a plan on a national level and to report to the Society.

Dr. Shiflett also recommended that because of the great amount of business accumulated during the summer when no meetings are held the September meeting be devoted exclusively to business.

Mr. Palmer-Ball's proposal to erect a medical center on St. Matthews land donated by him, consisting of hospital, clinic, and offices for physicians, was presented by Dr. Kinsman. He stated that Mr. Palmer-Ball is receptive to suggestions.

It was moved by Austin Bloch, M. D., that the first fall meeting be limited to business and that the scientific program be omitted. After discussion, in which Dr. Bloch pointed out this would be the only meeting between the summer recess and the State meeting and that policies would be formulated at the September meeting, the motion carried.

After the business meeting L. Wallace Frank, M. D. spoke on "Breast Cancer: A Study of Ten Year Results." A discussion followed by George B. Sanders, M. D., R. A. Bate, M. D., and Dr. Shiflett with closing remarks by Dr. Frank.

Robert C. Long, M. D., Secretary



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SEARLE

RESEARCH IN THE SERVICE
OF MEDICINE

A joint meeting of the Jefferson County Medical Society and the Louisville Bar Association was held on June 16, 1952, in the Grand Ballroom of the Seelbach Hotel. Eighty-two members and guests attended the dinner with an increased number at the meeting.

Following dinner, President R. R. Slucher, M. D., called the meeting to order.

Robertson O. Joplin, M. D., spoke briefly and asked members of the Bar Association to stand and be recognized. The physicians were then asked to stand. The meeting was then open to discussion.

E. L. Shiflett, M. D., gave a detailed account of his complaints against the lawyers and their methods of dealing with physicians as witnesses in court.

Answer was made by Attorneys John M. Robsion, Jr., Blakey Helm, Judge L. R. Curtis, and others.

Several other physicians spoke, including G. G. Altman, M. D., and J. Kenneth Hutcherson, M. D.

One lawyer discussed fees charged by physicians called to testify and cited an instance where a local physician had sent a bill for \$200.00 when he had been in court not more than 45 minutes. He said he hoped a plan could be worked out so that fees averaging not more than \$25.00 to \$35.00 would be paid to physicians for the average testimony in court.

Frank M. Gaines, M. D., requested the attorney's help in formulating new laws in relation to court procedures when patients are to be confined to mental hospitals.

One duty, it was agreed, of the new joint committee of lawyers and physicians will be to investigate malpractice complaints against doctors in order to determine whether they have sufficient basis to be brought into court.

Robert C. Long, M. D., Secretary

SCOTT

The Scott County Medical Society met at the John Graves Ford Memorial Hospital in Georgetown on August 7, 1952. The following members were present: Drs. D. E. Clark, Jr., A. F. Smith, E. C. Barlow, F. W. Wilt, and H. V. Johnson. Guests present were: Miss B. Daniel, Hospital Superintendent, and Mr. Johnny Whitcomb, a medical student of Harvard University.

The Secretary read a letter reporting that the State Mobile Cancer Clinic will visit Scott County November 19, 20, and 21. Clinics will be held at the new Health Department building on North Hamilton Street.

H. V. Johnson, M. D., Secretary

SCOTT

The regular monthly meeting of the Scott County Medical Society was held on September 4, 1952, at the John Graves Ford Memorial Hospital in Georgetown. The following members were present: Drs. W. S. Allphin, P. H. Crutchofield, H. G. Wells, F. W. Wilt, E. C. Barlow, and H. V. Johnson. The Society had as their guests Dr. and Mrs. Waller Bullock of Lexington and Mrs. W. H. Coffman of Georgetown.

The reading of the minutes was omitted and the time given to Mrs. Bullock who spoke on the Ephraim McDowell Shrine at Danville, illustrated by some pictures of the home. After her talk it was moved and seconded that each member of the Scott County Medical Society donate ten dollars to the maintenance of the Shrine.

H. V. Johnson, M. D., Secretary

In Memoriam

ROBERT H. PORTER, JR., M. D.

Glasgow

1876 - 1952

Dr. Robert H. Porter, Jr., of Glasgow, died Friday, July 18, 1952, following an illness of a year.

Dr. Porter was a graduate of the University of Virginia and in 1901 was graduated from the Rush Medical College, Chicago, Illinois. He then practiced medicine in Glasgow until 1917, at which time he went to Chicago and practiced until 1940. Upon leaving Chicago, Dr. Porter resumed his practice in Glasgow. He was a member of the Barren County Medical Society.

WILLIAM CLIFTON RICHARDS, M. D.

Glasgow

1888 - 1952

Dr. William Clifton Richards died July 31, 1952, of a heart attack at the Samson Community Hospital, Glasgow, after an illness of two weeks.

Dr. Richards was born in Gallatin, Tennessee. He was graduated from the Hering Medical College, Chicago, Illinois, on June 6, 1912, and came to Glasgow as a young man, where he practiced medicine for forty years prior to his death.

Active in civic affairs in Glasgow, Dr. Richards was Chairman of the Barren County Board of Health and Past President of the local Rotary Club and of the Glasgow Chamber of Commerce.

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ALEXANDER NETTLEROTH, M. D.**Louisville****1869 - 1952**

Dr. Alexander Nettleroth, general practitioner, Louisville, died September 26, 1952, after a brief illness.

Dr. Nettleroth, who celebrated his 83d birthday on September 11, had maintained offices in the Weissinger-Gaulbert for about 40 years, according to the building's rental office.

A graduate of Louisville Male High School, Dr. Nettleroth received his medical degree from the Louisville Medical College in 1899. He served in Cuba with the Third Division's medical staff during the Spanish-American War. In World War I he was a captain in the Army Medical Corps.

He was a fellow of the American Medical Association and a member of the Jefferson County Society and Kentucky State Medical Association.

F. M. TRAVIS, M. D.**Frankfort****1883 - 1952**

The following resolutions on the death of Dr. F. M. Travis, Frankfort, were passed by the Staff of The Kings Daughters Hospital, Frankfort, August 28, 1952.

WHEREAS: God in His Infinite Wisdom has seen fit to remove from our midst our long-time friend and fellow-practitioner, Dr. Finis Mace Travis; and,

WHEREAS: Dr. Travis was an honored member of the Staff of this Hospital, having served faithfully, diligently, and with credit to himself and the Hospital since 1926, and has held many offices of this Staff, including that of President, and,

WHEREAS: Dr. Travis has practiced in this Community for 26 years, having been considered by his Colleagues and patients to have been a man of great integrity and marked ability. He was respected by his Colleagues and loved by his patients. He was especially interested in X-Ray, for which he had devoted some 20 years of his life in perfecting himself in this specialty. He had just been elected to the North American Radiological Society. He has been a faithful member of the County Medical Society and has served it in practically every office it has to offer, including that

of President. He has been always interested in the State Medical Society and generally attended its meetings. He was a member of The Franklin County Board of Health and later of the State Board of Health for many years. At one time he was President of the Fifth District Medical Society; and,

WHEREAS: He was interested in the Community in which he lived and particularly in his Church on whose Board of Deacons he had served for many years and which he supported by tithing. He was a member of the Lions Club for over 20 years and was a Mason, a member of the Scottish Rite, and of the Shrine. His devotion to his wife and family was probably the main passion of his life; therefore

BE IT RESOLVED: That the Staff of this Hospital express its regrets for the loss of this valuable member and extend its sympathy to his family and loved ones, and,

BE IT FURTHER RESOLVED: That these resolutions be emblazoned on the minutes of the Staff and that a copy of the same be sent to the Kentucky State Medical Society and to his family.

By the Committee on Resolutions for
The Kings Daughters Hospital

(Signed) W. S. Snyder, Jr., M. D.

(Signed) R. M. Coblin, M. D.

(Signed) E. K. Martin, M. D.

FRANCIS E. BELL, M. D.**Ludlow****1898 - 1952**

Dr. Francis E. Bell, Ludlow physician for 25 years, died August 26, 1952. Dr. Bell was born at Murray, Kentucky, Calloway County, October 11, 1898. He graduated from Murray High School, Murray, and from the University of Louisville Medical Department in 1925. After graduating, he was Resident Staff Physician at City Hospital, Louisville; from there he went to West Baden Hospital Clinic, West Baden, Indiana, and was there two years; from West Baden he went to Chicago, Illinois, for about one year, after which he came to Ludlow, Kentucky, in 1929, and established his practice.

Dr. Bell was Vice-President of the staff at St. Elizabeth's Hospital in Covington; also on the staff at Booth Memorial Hospital. He was a member of the American Medical Association, the American Society of Anesthesiologists, the Kentucky State Medical Association, the Cincinnati Society of Anesthesiology, and the Southern Medical Association.

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Trauma and Vasospasm

JOHN B. FLOYD, JR., M. D.

and

J. F. VAN METER, M. D.

Lexington

Trauma occurs frequently to all parts of the body to all degrees from many causes. The local and general effects of abrasions, lacerations, contusions, sprains and fractures are noted, and therapy is started with the purposes of relieving pain and of returning function to normal as quickly as possible.

Immediate treatment of wounds consists of steps to stop hemorrhage, to relieve shock, to control pain, and to re-establish the normal alignment of lacerations and fractures. Many times vasospastic impulses arise as result of trauma, and may bring about undesirable complications or side effects which may act to interrupt the normal healing process, or to prolong the convalescence.

Vasospasm

Vasospasm is an unnatural and abnormal contracture of muscle cells of arteries and veins. On the other hand vasoconstriction is a natural and normal response to pain or trauma, as a manifestation of the so-called "alarm reaction," and as a part of the autonomic nervous system's attempt to regulate body heat.

Afferent Pathway

The afferent pathway of the impulse originates in the sensory endings of a variety of somatic structures such as the skin, fat, fascia, tendons, joint tissues, periosteum, and muscles. It continues proximally through the cell station in the

dorsal root ganglion to a synapse in the posterior horn, some fibers rising in the postero-lateral tract and some fibers crossing to the lateral spinothalamic tract on the other side of the cord for their ascension. Through cross fibers there is a synapse with sympathetic cells in the lateral horn cells of the same spinal segment.

Efferent Pathway

The efferent pathway (pre-ganglionic) passes through the anterior spinal root and mixed spinal nerve, to split off into the white ramus communicans and extend into the sympathetic ganglion where connection is made with the post ganglionic pathway. The post ganglionic fibers make up the emergent gray ramus communicans which continue into the anterior primary ramus and posterior primary ramus, innervating blood vessels, sweat glands, and erector muscles of hairs.

The vasomotor changes are varied and depend on the degree of damage and the duration of the injury. Coldness, pallor and cyanosis from vasospasm, gooseflesh from the contraction of erector pila muscles, and increased sweating from over stimulation of sweat glands are early signs.

Trophic Changes

The late signs are the so-called trophic changes, the hands and feet being the site of predilection. The skin folds become shallow and smoothed out, the skin inelastic, shiny, and mottled. Ulceration occurs easily, and healing is retarded. Fi-

brosis of subcutaneous tissue follows chronic edema, in turn being followed by shrinkage and atrophy. Finger nails may be distorted by ridges, curves, or brittleness, or may fall out. Hair may fall out or grow rapidly. Bones may be decalcified and demineralized. Joints may be stiffened.

Contusions, abrasions, lacerations, puncture wounds, and injuries to such deeper tissues as arteries, veins, nerves, and bones will be briefly discussed with special reference to the role of vasospasm. Then certain peripheral vascular diseases will be mentioned, and the aggravating effect of trauma will be brought out for comparison.

With a normal vascular system and mild to moderate injuries, vasospasm is usually no problem. Application of cardinal principles of treatment, that is splinting, rest, and heart level position, suffices for maintenance of adequate circulation.

Symptoms of Vasospasm

When evidence of an absence or diminution of circulation is noted by coolness, pallor, and an absence of pulsation, especially if accompanied by more pain than normal, further vasodilation methods must be employed. Blood replacement by transfusion will correct compensatory peripheral vasoconstriction. Reflex vasodilation of the lower extremities may be assisted by use of a heat cradle over the abdomen, never over the injured limb. The same for the upper limb may be true with heat directed to the upper thorax and neck. Regional sympathetic ablation by the use of procaine frequently will secure the maximum effect, except for those rare arterial injuries with local spasm that even fails to respond to proximally placed intra-arterial drugs.

Contraindication in Treatment

Definitely contraindicated for peripheral vasodilatation are those ganglion blocking drugs which affect the entire body. A seriously injured patient could be placed in jeopardy with such medication. The logical step for vasodilatation of a region is to employ regional sympathetic anesthesia, not general sympathetic anesthesia.

Complications

The common complication of traumatic injuries, infection, is frequently attended by vasospasm. The throbbing pain noted

at times, especially in puncture wounds, is greatly influenced by vasospasm, and regional sympathetic block usually relieves a lot of the pain at once. In spite of clinical erythema of infected wounds, plethysmography studies now reveal arteriolar vasospasm.

The increased blood supply following vasodilatation not only hastens arrest of the infection, but hurries healing. It will not compensate for necrosing sutures and ligatures, nor for skin flaps sewed in place under tension. It is not intended that vasodilatation be a routine measure for use in injuries. As an adjunct in the handling of early, acute complicated injuries, however, vasodilatation by regional sympathetic anesthesia may definitely fill a need in selected instances.

Signs and Symptoms

Deeper tissue injuries frequently produce prolonged signs and symptoms. The sharp disabling pain of a sprained ankle is often relieved by the use of one or two cubic centimeters of procaine injected at the most tender spot. Strapping for support of injured tissues is not to be overlooked as the key splinting treatment.

Vascular contusion may be followed by intense vasospastic phenomena characterized chiefly by edema and pain. Uninterrupted edema results in chronic crippling as an after effect of the subcutaneous fibrosis and scarring which is the result of precipitation of fibrin from the heavily protein edematous tissue fluid. For this reason edema should not be tolerated, and aggressive attempts to control it should be initiated early. These methods aim at edema subsidence by compression with elastic materials or by elevation of the limb, and by introduction of vasodilatation. Vasodilatation increases arteriolar pulsations, which are the pumps which normally return tissue fluids centrally, and thus effects a reduction in edema tension.

In spite of excellent handling, a few examples of persistently refractory injuries may be the result of an underlying peripheral vascular disease. Rubor on dependency and pallor on elevation are the cardinal signs of arterial disease.

General Method of Treatment

General methods of handling are most effective if simple means of vasodilatation are first emphasized to the patient. These include sedation if necessary to con-

trol emotional upsets, avoidance of exposure to cold, and abstinence from tobacco in any form. Exposure to any of the above factors is followed by an abnormal degree and persistence of constriction in peripheral vascular diseases.

Regional sympathectomy then definitely has a place in our list of treatments of these diseases, without question, if beneficial effects are noted from use of a temporary regional procaine block. A remarkable salvage of limbs with less disability follows use of selected lumbar or cervico-dorsal sympathectomy.

Thromboangitis Obliterans

Thromboangitis obliterans, or Buerger's Disease, is the most common vascular disease unrecognized in injuries, because its susceptible age group of twenty to fifty covers most of those workers who are subject to injury. It also corresponds with the age when the use of tobacco is heaviest. The disease is an inflammatory obliterative process involving medium sized arteries and veins, and is characterized by remissions, exacerbations, and migratory phlebitis. Acute ulcers, cellulitis, or soft tissue gangrene are signs which suggest use of splinting of the extremity for proper treatment and protection. Oscillographic studies here are practical, especially needed in industrial medicine, to indicate the status of the larger peripheral vessels. Abstinence from tobacco and regional sympathectomy are the keystones of effective therapy. These patients require careful evaluation before a statement as to the "causative" or "aggravative" influence of trauma can be made.

Arterio-Sclerosis Obliterans

Arterio-sclerosis obliterans is the most common vascular disease figuring in injuries. Its presence may not be noted for years. Intermittent claudication and coldness are the earliest symptoms. Trivial injuries may assume major proportions with delayed healing and spreading cellulitis. Sudden occlusion by mural emboli occurs in this disease. Many may occur while at work. It should not be compensable unless the work is definitely noted to be an aggravating factor. These

episodes follow the normal course of the disease.

Scalenus Anticus Syndrome

The scalenus anticus syndrome, identified by Nafziger, described by Ochsner, DeBakey and Gage, and classified by Simeone must be mentioned. Quite likely, its most common manifestation is of superficial pain in the upper anterior chest or breast. Patients suspect the presence of heart trouble or breast cancer. Pressure over the muscle will reproduce the pain. Procaine injected into the muscle belly will relieve the pain. Cervical arthritis and ruptured cervical discs must be ruled out. Neck traction may be a safe therapeutic procedure in all three lesions, for scalenus muscle spasm may be a secondary manifestation. Division of the muscle belly may be a necessary step. While "dropped shoulders" and "elongated necks" may pre-dispose a stretched scalenus muscle to initiate spasm, occupations requiring sweeping or ironing motions of a housewife will precipitate excessive strain on the muscle. Occupations requiring the arms to be held above the head for periods of time result in similar symptoms referable to brachial plexus compression.

Mention will be made of other illustrative injuries such as "writers cramps" seen in stenographers or concert pianists, and jack hammer fingers with vasospastic responses in digits quite like Raynauds Syndrome.

Summary

1. General principles of treatment of injuries are mentioned.
2. The influence of vasospasm on injuries is illustrated, and the pathway of the impulse is outlined.
3. Vasodilation adjuncts are discussed in relation to problems presented.
4. The sinister influence of unrecognized peripheral vascular disease is commented upon, with reference to compensability.
5. Occupational stress upon otherwise normal physiques is illustrated through discussion of the scalenus anticus syndrome.

A Simplified Approach to the Diet Therapy of the Diabetic

MARTIN H. BOLDT, M. D., and SHIRLEY K. BOLDT, B. Sc.

Louisville

Introduction

The advent of insulin in 1922 has given the person with diabetes mellitus an increased life expectancy (1). The development of long acting insulin has made this longer life more tolerable. Too often, however, the diabetic is isolated from the rest of the population because of frustrations and anxieties about his diet. This paper presents a discussion of the emotional problems of such individuals with particular reference to their diets. Some physicians have stressed the importance of initial hospitalization for treatment and instruction of the newly discovered diabetic (2). It is our belief that this is generally unnecessary. It may even be psychologically traumatic to the patient who has just been informed that he may have a chronic disease. A simplified method for dietary instruction is outlined which will minimize such emotional disturbances and which is easy to use in office practice. This method is based on the newer philosophy of dietotherapy with emphasis on the fact that the diabetic diet is similar to that of a comparable normal individual. It enables the physician to prescribe a diet expressed in positive, concrete terms easily put to use by the patient. It has been used successfully in both clinic and office practice for five years.

Psychological Problem Involved

Since modern thought considers the patient's personality in a social setting, every contact with the physician becomes influential. It is mandatory that the doctor be willing to spend the necessary time to satisfy the patient's psychological needs. The manner in which the disease is discussed with the patient becomes a form of psychotherapy as does the kind of management that is suggested (3). Too often, however, management is thought of solely in mathematical terms expressed as units of insulin and grams of carbohydrates, protein and fat. Neglected is consideration of the patient's psychological reaction to the knowledge that he has fallen victim to an illness that will last as long as he lives. He will have already de-

veloped from prior knowledge of other diabetics preconceived ideas about taking insulin injections and about changing his established food pattern. Depending on his emotional maturity and personality his reaction to this will vary.

In obesity it is almost universally accepted that modifying the patient's food habits requires an insight into the patient's psychological problems. This is equally true in all instances where manipulation of diet is undertaken. It has been suggested that the so-called regressive aspects of the diabetic personality are related to the restriction of the conventional diabetic diet. This has been compared by Bayles and Ebaugh to the over-protective mother's attitude towards her three-year-old. He may respond by being a passive, compliant individual who all through life eats the right things to please "Mamma" or he may rebel in a manner that is rewarded by receiving the whole family's attention. An over-protective attitude by the physician may produce similar regressive behavior in adult diabetics (4).

Problem of Obesity

Obesity, which is frequently on a psychosomatic basis, is an important etiologic factor in adults with this disease. The same emotional mechanism may precede obesity leading to diabetes, particularly in the middle-aged patient with the latent disease (5). The greater incidence in obese individuals during middle age may have been explained in part by the experiments of Dohan and Lukens, (6,7) who showed that prolonged hyperglycemia in cats and dogs may lead to the establishment of a permanent diabetes. Clinical studies with obese persons over forty years of age having diabetes of varying severity have shown that loss of weight through dietary restriction improves carbohydrate tolerance provided the glycosuria and hyperglycemia are of short duration. Obese patients with neglected diabetes for many years, however, lost the ability to regain their tolerance (8). The need, therefore, for insight into the personality problems of the overweight patient with recently discovered diabetes is urgent.

The author wishes to express his gratitude to Dr. Morris Flexner for much encouragement and helpful criticism.

The physician is still left with the need to develop for and present to the patient the necessary modification that will bring about the desired degree of control. This should conform as closely as possible with the patient's established dietary habits. It must be done without the physician assuming the role of the over-protective parent or rigid disciplinarian. Whether the physician belongs to Joslin's strict school or to Tolstoi's free school or whether he is at a point somewhere between, he has to rely on the intelligent cooperation of the patient. To do this the patient must be presented with a diet plan that is simple, adequate, and sufficiently flexible so that he can mingle unobtrusively in society.

Food History of Patient

Before any attempt is made to develop the diet the physician must obtain from the patient a rather detailed food history. During this discussion the alert physician can detect significant attitudes about the role that food plays in his patient's life as well as many relevant facts about the patient's social and economic background. Information must be procured concerning his previous meal habits with specific details about his intake at breakfast, luncheon, dinner, between meals and bedtime. He must be questioned about where he eats his meals; at home, in the restaurant, or carried to work. It is important to know who is responsible for meal preparation for it is sometimes well to invite this individual to subsequent interviews.

Nutritional Requirements

Basic to the formulation of any dietary plan are the allowances set up by the Food and Nutrition Board of the National Research Council. If there is need to alter the weight of the patient adjustment may be made in the caloric requirement without significantly changing the other nutrients. The most recent allowances are as follows (9) as published for a man of sedentary occupation weighing 154 pounds (70 Kg.):

Calories 2400,
Protein 70 grams,
Calcium 1 gram,
Iron 12 mg.,
Vitamin A 5000 I. U.,
Thiamin 1.2 mg.,
Riboflavin 1.8 mg.,

Niacin 12 mg.,

Ascorbic acid 75 mg.

These nutrients can be obtained on a daily basis through using a variety of common foods. A dietary pattern called the "basic seven" set up by the National Research Council classifies foods into groups based on nutritive content and use in meals. This plan as shown below is basic for all individuals whether normal or diabetic.

Basic Seven Food Groups

1. Leafy green and yellow vegetables—1 or more servings daily.
2. Citrus fruit, tomatoes, raw cabbage—1 or more servings daily.
3. Potatoes, fruits and vegetables other than those above—2 or more servings daily.
4. Milk—2 or more glasses daily (Cheese may be substituted).
5. Meat, fish, poultry, eggs, dried peas and beans—1 or 2 servings daily.
6. Bread, flour, cereals, whole grain, enriched or restored—Amount each day depends on caloric requirements.
7. Butter or fortified margarine—Amount daily depends on caloric requirement.

It is apparent, then, that the diet of the whole family, including that of the diabetic, can be built around the same nucleus with the nutritive status of all benefited. We see, therefore, that the diabetic diet is a normal diet. The era when foods, the so-called diabetic foods, were used has passed and no longer deserves a place in modern medical management of this disease. It cannot be overly stressed that the diabetic is not to be ostracized through a bizarre diet that makes him different from others.

The quantitative intake of the foods from these basic 7 food groups must, however, be estimated for the diabetic so that the consumption can be maintained on a par with his energy requirement and with his insulin dosage. The need for weighing or accurate measuring of the diabetic's diet with the accompanying mathematical gymnastics formerly required has fortunately been shown to be entirely unnecessary. We know, for example, that the chemical analysis of different samples of the same food frequently vary. This may in part be due to soil differences in which the food was produced. In addition, treat-

ment in commercial and home processing produces variation in nutritive value. It has been shown, for instance, that a roast cooked to the same degree of doneness will vary 5 per cent to 30 per cent in moisture content depending on the length of time and the amount of heat used in the cookery process. Likewise, if the water used in the preparation of vegetables is discarded, variation due to the amount of soluble carbohydrate lost will ensue (10,11).

In the formation of the patient's dietary regimen the physician need not be burdened with long and complex tables of computations for each food item. After considerable research and testing the diet therapy section of the American Dietetic Association has devised a short method of dietary calculation in which foods of similar composition were grouped together and mean values were established. They have been shown to have a deviation no greater than 2.5 per cent than when each individual food item is calculated separately. For example, all citrus fruits are lumped together and average size portions such as 1 medium orange, $\frac{1}{2}$ medium grapefruit, $\frac{1}{2}$ cup unsweetened citrus juice and 1 medium lemon are all considered as yielding 50 calories and about 11 grams of carbohydrates (12).

Simplified Method of Planning Day's Food

On this premise we have further simplified the method for calculating the approximate value of diets prescribed for the diabetic which is shown in Table 1. It should be reiterated that this scheme, simple though it may be, is not to be the concern of the patient. In actual practice moreover, we have found that a food plan for the individual patient can be devised without repeated mathematical calculation of the diet. Such diets can be flexible enough to conform in the maximum manner with the patient's previous food patterns and will meet his present modified dietary requirements. This is accomplished by Chart A which provides all elements of the basic 7 food groups. As suggested by the National Research Council amounts of bread, cereals and shortening are varied to comply with the Caloric needs of the individual. Those individuals with larger than average protein and caloric requirements are also provided with additional servings of milk, meat and equivalents.

Diet Charts

To assist the patient in procuring an interesting diet Chart B is provided. This table embodies the practical philosophy previously discussed, that foods of relatively similar composition can be grouped together and used interchangeably. If the patient is properly instructed to vary his daily selections from these lists individual food values will tend to strike those medians shown in Table 1. The patient is not advised to measure his food, but the indicated serving sizes are merely guides. In general, servings of vegetables are approximately one-half cup and the patient is told to determine what this amount looks like on his own china at home. By this method of classifying vegetables into only three groups the patient's menu planning is made easy as it eliminates the confusion inherent in 3, 6, 9, 12, 15, 18, etc., percentage classification categories. In Chart B the vegetables which may be eaten as desired contain very small amounts of carbohydrates.

Chart C lists supplementary information again based on Chart A. This permits added flexibility in the diet. Here, too, are listed further hints to make the diet palatable.

It has been our custom to avoid the use of free sugar and rich desserts, because the patient can best satisfy his nutritional needs with foods containing in addition to his carbohydrate quota vitamins, minerals and other nutritive elements. We suggest use of fresh fruits for dessert.

This method has been evolved over approximately a five year period and it has been used successfully in private practice as well as in a large out-patient clinic. It has been found sufficiently flexible with patients of very varied economic, social and national backgrounds provided adequate instruction is personally afforded the patient. Any alterations required as indicated by subsequent follow-ups are discussed with the patient in detail.

An example of a diabetic diet for a specific need is shown by selecting an obese middle aged woman whose occupation is primarily sedentary. Her nutrition requirements according to the National Research Council would be as follows:

Calories—1200,
Protein—60 grams,
Calcium—1 gram,
Iron—12 mg.,

Vitamin A—5000 I. U.,
Thiamin—1.0 mg.,
Riboflavin—1.5 mg.
Niacin—10 mg.,
Ascorbic Acid—70 mg.

These nutritional requirements can be provided by filling in Chart A with the following dietary outline. The accompanying sample menu is provided to further clarify its use:

Although we actually calculated the nu-

tritive value in respect to all nutritional elements to determine the accuracy of this menu selection for the purpose of this paper, the physician utilizing this scheme can be assured that by using even the minimum of foods suggested in the basic 7 food groups his patient will be obtaining his nutritional requirements. In the beginning the physician may wish to make a rapid-Caloric calculation of the suggested foods by using Table 1, but he will find that with a little practice he will be able to estimate the amount of food for the patient without referring to calories.

SUGGESTED PLAN FOR OBESE MIDDLE AGED SEDENTARY DIABETIC WOMAN

Suggested Diet Outline

Sample Menu

BREAKFAST

Fruit-Citrus—1 serving
Egg—1
Toast—1 Butter—1 tsp.
Coffee

BREAKFAST

½ Grapefruit
Soft cooked egg
1 slice toast and butter
Coffee with small amount of milk if desired

LUNCH

Meat or equivalent—1 portion
Group A vegetable—1 portion
Green salad—as desired
Milk—1 glass
Fruit—1 portion

LUNCH

Salad Platter—
Drained tuna fish, lemon wedge, carrot strips, tomato, celery, radishes, scallions
Milk
Baked apple

DINNER

Clear broth—as desired
Meat—1 portion
Group A vegetable—1 portion
Group B vegetable—1 portion
Green salad—as desired
Coffee or tea
Fruit—1 portion

DINNER

Bouillon
Broiled tenderloin steak
Baked potato (medium size)
Broccoli
Lettuce hearts with vinegar dressing
Tea with lemon
Mixed fresh fruit cup

BEDTIME FEEDING

Milk—1 glass

BEDTIME FEEDING

1 glass milk

Summary

1. The emotional problems of the diabetic with special reference to his diet are discussed.

2. Advisability of office management is explored.

3. A simplified method of dietary instruction to the diabetic is presented.

4. The similarity between a diabetic diet and one for a comparable normal individual is emphasized.

5. Newer findings with reference to food classifications are presented. Original charts providing application of these findings are offered.

6. Illustrative examples are included which demonstrate the use of this method.

TABLE 1
Simple Guide for Calculating Diabetic Diets

Food Groups	Common Portion Size	Carb.	Pro.	Fat	Cal.
Group A Vegetables (Asparagus, cabbage, beets, carrots, etc.)	½ cup	7	1	—	32
Group B Vegetables (Potatoes, corn, rice)	½ cup	20	2	—	88
Bread—1 slice					
Cereal—¾ cup					
Saltines—6		20	2	—	88
Fruit	½ cup	10	1	—	44
Lean meats	3 ounces	—	20	15	215
Egg	1 medium	—	6	6	78
Butter					
(Or light cream—1 tb.)	1 tsp.	—	—	4	36
Milk	1 glass	12	9	9	165

CHART A

Suggested Diet Outlines

BREAKFAST:

Fruit
Cereal
Eggs
Toast
Butter
Milk
Coffee

LUNCH:

Meat or equivalent
Group A vegetables
Green salad
Bread
Butter
Milk
Fruit

DINNER:

Clear broth
Meat or equivalent
Group A vegetables
Group B vegetables
Green salad
Bread
Butter
Milk
Fruit

Bedtime Feeding:

.....
.....
.....
.....

CHART B

Diet Information for Diabetics

EAT AS DESIRED:

Chinese cabbage
Celery raw
Chicory raw
Escarole raw
Lettuce raw
Radishes
Watercress
Cucumbers

GROUP "A" VEGETABLES: AVERAGE SERVINGS:

Asparagus	7 stalks
Bamboo shoots	¾ cup
Bean sprouts	1 cup
Broccoli	2 stalks
Cabbage	½ cup
Cauliflower	3 flowerlets
Eggplant	½ cup cooked
Mustard greens	½ cup
Green peppers	2 small
Sauerkraut	½ cup
Summer squash	½ cup
Spinach	¾ cup
Sorrel	½ cup
Tomatoes, canned	½ cup
Tomatoes, fresh	1 medium
Tomato juice	½ cup
V-8 cocktail veg. juice	½ cup
Turnips	½ cup
Beans, green, snap fresh	½ cup
Beets	½ cup
Carrots	½ cup
Onions	1 large
Peas, canned	½ cup
Peas, fresh	¼ cup
Pumpkin	½ cup
Rutabagas	½ cup
Hubbard squash	½ cup

GROUP "B" VEGETABLES: AVERAGE SERVINGS:

Succotash	1/2 cup
White potatoes	1 small
Corn	1/2 cup or 1 small 5" ear
Beans, kidney or lima	1/2 cup
Sweet potatoes	1/4 cup or 1/2 small potato
Parsnips	1/2 cup
Rice, spaghetti, noodles	1/2 cup

FRUIT:

Apples	1 small
Applesauce	1/2 cup
Apricots, dried halves	3
Bananas	1/2 medium
Blueberries	1/2 cup
Blackberries	1/2 cup
Cantaloupe	1/2
Cherries, fresh red, sweet	10 only
Cherries, canned	1/2 cup
Grapefruit juice (unsweetened)	1/2 cup
Grapes	35 seedless, 15 seeded or 8 large black
Oranges	1 medium
Orange juice	1/2 cup
Peaches	1 medium
Pears	1/2 large
Pineapple juice (unsweetened)	1/3 cup
Plums	2 medium
Prunes	3 small
Prune juice (unsweetened)	1/4 cup
Strawberries	3/4 cup or 10 large
Tangerines	1 medium
Watermelon	1 small slice or 3/4 cup diced
All fruits (canned) must be water packed.	

CHART C

Supplementary Diet Information for Diabetics

Foods which may be substituted for one (1) slice of bread:

Cereals, 3/4 cup cooked or 1 cup dry
 Soda crackers 4; saltines 6; Ry-krisp 3
 Two (2) portions of any fruit
 Any vegetable selected from Group B

Foods which may be substituted for medium size portion of lean meat:

Poultry, fish, fresh or canned
 Clams, 15 small, oysters 10 medium
 Cheese, American, 1 thick slice, eggs two (2)

Cottage cheese, four (4) tablespoons.

Foods which may be substituted for two (2) teaspoons butter:

Oleomargarine, 2 teaspoons, peanut butter, 3 teaspoons

Mayonnaise, 2 teaspoons, oil, cooking, 2 teaspoons

French dressing, 4 teaspoons, fats, cooking, 2 teaspoons

Light cream, 2 tablespoons

Heavy cream, 1 tablespoon.

Further Hints:

Plain mineral, carbonated and spring water may be used. Avoid gingerale, cola or other sweetened beverages.

Lean meats should be utilized. They should not be fried, but should be simply prepared by broiling, boiling or roasting.

As Desired:

Clear soup such as broth and consomme, tea, coffee, saccharine, vinegar, lemon juice, vegetables for raw green salads.

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Upper Extremity Pain

With particular reference to the diagnosis and treatment of lesions in the region of the intervertebral foramina of the cervical spine, and in the supraclavicular fossa

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Upper extremity pain is a very common complaint among patients referred to Neurosurgical Clinics by physicians and surgeons representing many specialties; therefore, we felt that this subject would be acceptable to a group such as yours, particularly since so much has been accomplished in recent years to solve this interesting yet challenging problem.

Needless to say, there are numerous pathological and postural conditions which cause pain in one or both arms. Many of these are obvious or unusual, and will not be considered here. It is our purpose to deal mostly with lesions which are not readily apparent, but which account for most of our diagnostic and therapeutic problems. These are to be found in or near the foramina of the cervical spine and in the supraclavicular fossa. Usually symptoms are limited to, or are more pronounced on one side, although they may be present bilaterally. For the most part the affected extremity shows little or no abnormality.

Prior to 1943, when Semmes and Murphy¹ described lateral herniations of the nucleus pulposus in the cervical spine, there was little opportunity to study the effect of injury limited to individual spinal nerve roots. This important contribution, together with many subsequent ones dealing with the same subject,^{2, 3, 4} has led to the recognition of syndromes which point precisely to the level of spinal involvement.

Large central herniations of the nucleus pulposus and intraspinal tumors may produce upper extremity pain, but these lesions are not common, and as a rule they manifest their presence in a more significant form, i.e., spinal cord compression.

Cervical Disc Lesions

Rupture of cervical discs is an uncommon occurrence when compared with rupture of lumbar discs. In our Clinic the ratio of cases treated surgically has been

about 1-25. This is not a correct comparison inasmuch as surgery was recommended in a small percentage of patients in whom a diagnosis of lumbar disc lesion was made, whereas most patients with rupture of a cervical disc were operated upon. The probable ratio is about 1-50.

In order of frequency, discs rupture at C-6, C-5 and C-7, and they favor the left side in a ratio of about two to one. Neck pain is absent or negligible, but the referred pain is excruciating. For the most part, it extends over the shoulder and upper arm, and to some extent over the forearm. Rarely is there pain in the hand, but patients often complain of discomfort which usually takes the form of numbness and tingling in the fingers. Occasionally, pain also radiates to the anterior chest wall and scapular region. The suddenness of onset, and the distribution of pain and numbness not infrequently suggest coronary thrombosis, particularly since the left side is more often involved. The severity of the arm pain, which is almost intolerable, should always suggest a disc lesion rather than other conditions to be discussed here. Contrary to what one might assume, ordinary movements of the neck may be free and painless. However, marked hyperextension almost invariably aggravates the pain and numbness, and in some cases brings on numbness and tingling in fingers not previously noted by the patient, and gives the examiner a clue as to the interspace involved. Many patients suffering from an acutely ruptured cervical disc sleep in a sitting position, because in recumbency intensity of the pain is greatly increased, probably due to engorgement of veins surrounding the affected nerve root.

We have not been impressed with the role of trauma. The injury, if any, ordinarily is of minor degree, as is also true to a large extent when lumbar discs are involved. Ruptures occur at levels of greatest mobility where weak and degenerated tissues would be expected to give way. The weakness of the annulus fibrosus and the disruption of the nucleus pulposus are not due to advanced age. In our

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series the average age was 43. The oldest patient was 59, and the youngest 29.

The usual history is that of sudden onset of extremity pain increasing to maximum severity within a period of hours or a few days without a history of local pain which often precedes or accompanies the rupture of a lumbar disc. The greatest number of ruptures occur at C-6 with compression of C-7 nerve root which produces numbness and tingling over the palmar surface of the thumb, first, and second fingers, especially in the first finger. Patients usually complain of sensory disturbance, or else it can be brought out on sensory examination, or by hyperextension of the neck. Herniations between C-5 and C-6 affect C-6 nerve root, and produce sensory deficits over the posterior aspect of the thumb and forefinger (radial distribution). Herniations between C-7 and C-8, the least common site, affect C-8 nerve root, and cause numbness in the ulnar distribution, most pronounced over the palmar surface of the fourth and fifth fingers. Keegan⁵ has shown that the sensory loss from a lesion at any of these levels extends up into the arm, but it is unusual for a patient to complain of numbness or tingling above the level of the hand.

The location of the sensory disturbance is by far the most important factor in determining the spinal level, as the distribution of pain is essentially the same in all cases.

In acute cases, it is obvious that pain is intense, but the appearance and movements of the extremity are unaffected. Also, normal movements of the neck are unrestricted and painless. Further examination reveals: Tenderness to pressure over the spinous processes at the level of the rupture, and pressure at this point may cause aggravation of the pain in the arm; aggravation of arm pain, together with increased numbness and tingling in the fingers on extreme hyperextension of the neck; marked tenderness over the brachial plexus; possible diminution of the biceps or triceps reflex if the lesion

is at C-5 or C-6, respectively; impairment of sensation in the distribution of the affected nerve root; and elimination or reversal of the normal spinal curvature.

The symptoms and signs of a ruptured cervical disc are characteristic of this disorder; therefore, the diagnosis is not difficult. On the basis of clinical findings alone, we have verified the diagnosis in 37 of 42 patients operated upon. The five negative explorations occurred early in the series before the clinical picture was well established. In the last 20 cases, the diagnosis was verified in each instance. Because of the reliability of clinical findings, we have not used myelography. Spontaneous recovery is not unusual, and the incidence of recurrence after either spontaneous relief or surgical treatment must be extremely low. In our series of 37 patients operated upon, and in a somewhat smaller group of patients who recovered spontaneously, there have been no recurrences insofar as we have been able to ascertain. This observation goes back to 1943; in fact, our first patient was operated upon a few weeks prior to the original publication on this subject by Semmes and Murphy, but of course after their work was already well under way.

In the management of cervical disc cases, we have been guided by the fact that these lesions are potentially dangerous, because of their proximity to the spinal cord, and that a sudden massive extrusion could bring on quadriplegia. For this reason, we have favored surgery rather than risk conservative methods unless symptoms were abating.

Both halter and skeletal traction were used in a few cases, but the results were not impressive. In fact, some patients complained of more pain while traction was in force. As mentioned previously, the recumbent position increases the severity of the extremity pain, and it may be that posture rather than traction accounted for the greater pain during this type of treatment. Traction with the patient in a sitting position, or propped up in bed, should be better tolerated.

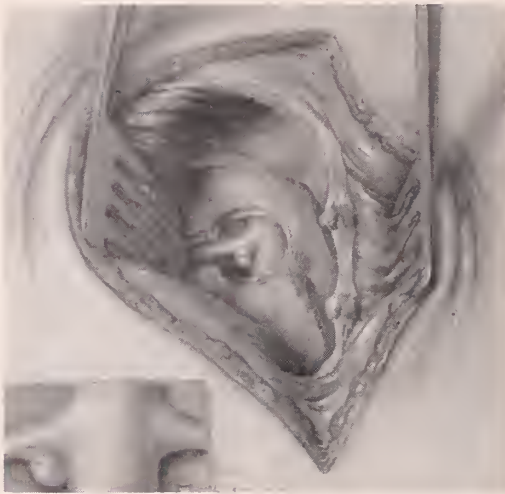


FIG. 1—Surgical exposure of a ruptured cervical disc. In order to protect the spinal cord less bone is removed from over the cord than is shown in this sketch. In most cases the herniated mass is completely covered by the nerve root.

Operation (Fig. 1) for removal of small lateral herniations is not difficult, and the results have been excellent. All patients in this series were completely relieved of pain, and none was handicapped in any way as the result of surgery.

Arthritis of the Cervical Spine

Arthritis of the cervical spine is a very common condition in persons beyond forty years of age. Generally, symptoms of a local nature, such as a grating sensation in the neck, limitation of motion, and attacks of acute or subacute neck pain, predominate; whereas, in some cases radiating pains with or without local symptoms predominate. Patients in the former group usually tolerate their discomfort, or rely on simple measures for temporary relief. Patients in the latter group require specific treatment, and it is their problems which we wish to discuss.

The anatomy of the cervical spine is such that comparatively minor abnormalities may cause compression of nerve roots resulting usually in pain and hyperesthesia in one or both upper extremities.

The degenerative and arthritic process affects mainly the interspaces at C-5, 6, and 7, and at these levels the normal foramina are not much larger than the nerves which pass through them. It is most unusual to find diminution in the size of the foramina above C-4; and the spinal nerves at this higher level are smaller, yet their foramina are larger than those in the lower cervical spine.

The arthritic process which concerns us here is almost entirely limited to that

segment of the cervical spine where rupture of discs occur; all of which complicates the diagnostic problem, but indicates that extreme mobility with its resultant wear and tear are important factors in the production of these pathological conditions.

Lipping at the postero-lateral aspect of the vertebral bodies, together with reduction in size of the adjacent foramina, as shown in Figure (2B), may cause nerve root compression not only resulting in arm pain, but in actual weakness and disability, usually limited to the hand. These cases fall in an older age group as would be expected. In a study of 50 cases, Turner and Oppenheimer⁶ found that most of the patients were over fifty years of age, although a few were much younger.

Significant symptoms are usually limited to one side, but may eventually spread to the other extremity. The onset of pain may be insidious, and it is often preceded by numbness and paresthesias in the hand. While the distribution of pain and sensory loss may be very similar to that produced by a herniated nucleus pulposus, the pain is never as severe or disabling.

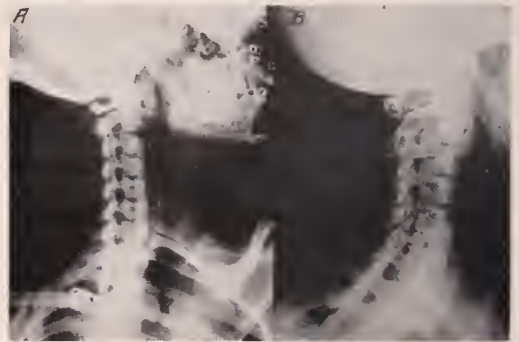


FIG. 2—Oblique views of the cervical spine. A, normal intervertebral foramina. B, marked reduction in size of the foramina at C-5 and C-6 due to hypertrophic arthritis.

Small herniations of the nucleus pulposus affect only one nerve root, and rarely cause much, if any, weakness of the extremity, whereas osteoarthritis usually involves one or more interspaces of varying degree; therefore, in these cases it is not uncommon to find more widespread sensory loss and even atrophy, particularly of the intrinsic muscles of the hand.

For the most part, the distribution of pain is not characteristic. It may simulate that caused by many different conditions; therefore, the diagnosis is made by exclusion. However, the long history,

age of the patient, evidence of multiple nerve involvement, and x-ray findings corresponding with the level of the affected roots leave little doubt as to the diagnosis. Patients with this type of arthritis frequently give a history of intermittent, subacute attacks of pain in the neck; but rarely is the neck pain severe, and usually there is very little, if any, restriction of normal movements of the cervical spine. Since the nerve roots are pinched in the foramina, hyperextension of the cervical spine, which further reduces the size of the foramina, may and often does precipitate or intensify the extremity pain. When C-8 and T-1 roots are involved, and there is numbness or paresthesia over the ulnar side of the hand, compression of the brachial plexus from a taut scalenus anticus tendon must be considered, and the differential diagnosis may not be easy. In cases such as this, hyperextension of the cervical spine is a valuable test, because it does not increase the pain when the scalenus anticus tendon is at fault. Also, tenderness to pressure is more pronounced directly over the brachial plexus when the lesion is in the spine.

Treatment can be effective, but it should be varied according to the severity of symptoms. Good results have been reported from the use of deep x-ray therapy⁷, but we have not had sufficient experience with this form of treatment to compare the results with those obtained from traction or surgery.

In patients with local pain or extremity pain without evidence of severe nerve injury, simple halter traction applied as shown in Figure (3) may be sufficient for relief of symptoms. This can be used in the home, and it has proven beneficial in a large number of cases. We recommend to our patients that they use a pull of 15-20 lbs. for fifteen minutes twice daily for two weeks, or until they become more comfortable, then reduce the treatment to once daily. Within a month the value of this form of treatment can be determined; then it may be discontinued or continued according to individual requirements. In obstinate cases we recommend hospitalization and the use of skeletal traction^{8,9}. (Figures 4 and 5). Very effective traction can be applied in this manner, and with minimal discomfort. This stronger and constant pull, which cannot be tolerated with the use of a halter, will break up adhesions and stretch ligaments; and thereby bring



FIG. 3.—Halter traction as may be used in the home.

about relief from pain in a group of patients who would not be benefitted by halter traction. Ordinarily we begin with ten pounds, and, if necessary, increase the pull to twenty-five pounds. Traction is maintained for a week or slightly longer, and then the patient is advised to use halter traction at home. The use of a collar is not advocated, because we believe that motion and exercise are necessary to maintain the decompression of nerve roots brought about by traction.

Hanflig¹⁰ has recommended forceful halter traction for very short periods of time, but due to the nature of the disease we believe that a continuous pull is more beneficial, and that it produces less trauma.

In cases of osteoarthritis of an extreme degree, where traction is ineffective, or the disease process has so greatly diminished the size of the foramina to make it useless, surgical decompression of the affected nerve roots is indicated (Figure 6). In 1945 we began treating these patients surgically. Then, and until recently, we assumed that others had unroofed cervical foramina to decompress nerve roots in cases of severe osteoarthritis, but in a recent review of the English literature we found no mention of this pro-

cedure. Figure (6) illustrates the relationship of the osteophyte to the nerve root. This is the same mechanism of pres-



FIG. 4—The author's method of using skeletal traction.



FIG. 5—Crutchfield tongs in place. Patients being treated for arthritis may be permitted periods of ambulation.

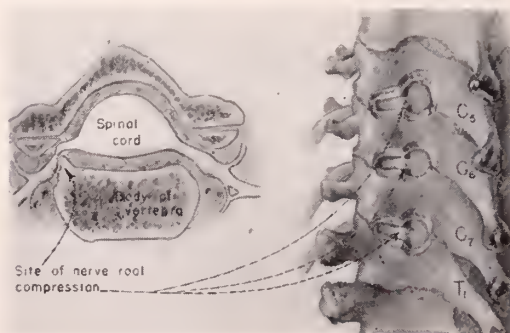


FIG 6—A surgical procedure for the relief of nerve root compression caused by arthritis, such as is shown in Fig. 2B.

sure that exists when a herniated nucleus pulposus compresses a nerve root, but because of the bony consistency of the protruding mass it is inconceivable that any treatment other than surgery would free the compressed nerve root.

We have employed this operation in four cases of advanced arthritis, such as shown in Figure (2B). At the time of the first operation we had not appreciated the significance of arthritis in the differential diagnosis; therefore, that patient was explored primarily for a ruptured disc. None was found, but the mechanism of pain, on the basis of arthritis, seemed obvious. In the subsequent cases, operation was performed primarily for the purpose of decompression. All patients were relieved of pain, and progressive weakness of the extremity was arrested, although in some numbness in the hand persisted. Residuals were expected due to irreversible changes in the nerve roots. Experience with herniated nucleus pulposus in the cervical spine has shown that numbness may persist indefinitely, even though there can be no question about the removal of the causative factor.

We have not found it necessary for these patients to use a collar or other type of support following operation. A small collar may be worn for a few weeks if it adds to the patient's comfort.

Cervical Ribs

In any discussion such as this, it is necessary to mention cervical ribs, (Figure 7), inasmuch as their presence must always be considered in patients complaining of unexplained upper extremity pain.

Supernumerary ribs usually arise from the seventh, and rarely from the sixth and fifth cervical vertebrae. They are bilateral in 70-80 percent of cases, but in most instances give symptoms on one side only. The right arm is more often involved, and this anomaly is more often found in females.

Reports indicate that cervical ribs occur in about 1 percent of the population. Todd¹¹ found them in 1.16 percent of the cadavers he studied. Adson and Coffey¹² reported 303 cases from the Mayo Clinic, and in 55 per cent of these the ribs were discovered accidentally. 84 patients were males, and 219 were females. Only 36 patients were operated upon. This figure proves, as we know, that comparatively few cervical ribs are significant insofar as treatment is concerned.

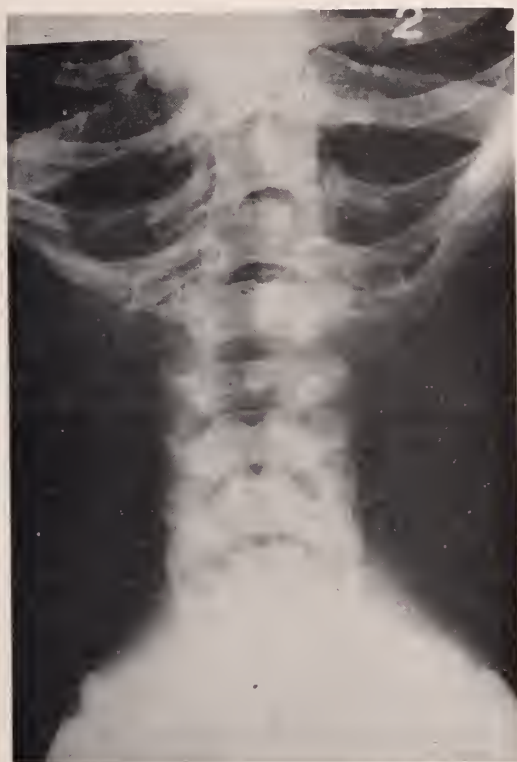


FIG. 7—Bilateral cervical ribs.

Symptoms rarely develop until the patient reaches adult life, and they usually come on insidiously, unless precipitated by trauma. A direct injury to the supraclavicular region, or a forceful downward pull on the shoulder may initiate an unusual degree of pain, and thereby attract attention to the presence of a cervical rib.

Pain may be limited to the supraclavicular region, or it may spread down the arm and into the hand. Usually it is more pronounced over the inner side of the arm and in the distribution of the ulnar nerve. Ulnar nerve symptoms are common, since it is the lower trunk of the brachial plexus which rides over the cervical rib. In some cases the middle trunk is also affected, and then there may be signs and symptoms of median nerve involvement. In most cases, numbness and paresthesias are limited to, or more pronounced over, the ulnar side of the hand. Atrophy of the intrinsic muscles of the hand is not unusual, but it is seldom these days that the condition goes unrecognized long enough to cause serious disability in the hand.

Strenuous movements of the arm, particularly those which depress the shoulder, and extreme rotary movements of the neck precipitate attacks of pain which may be severe for several minutes.

If the subclavian artery, which passes over the cervical rib, is severely compressed, vascular disturbances are present.

The treatment of choice is removal of the rib, particularly if there is objective evidence of nerve injury, and/or constant impairment of circulation in the extremity. Adson and Coffey¹² believed that decompression of the brachial plexus and subclavian artery by section of the scalenus anticus tendon would be as effective as removal of the cervical rib, but such has not been the case. In three of our ten patients whose ribs were removed tentotomy had given only partial or temporary relief of symptoms. When a patient needs relief, and the symptoms are mild, section of the scalenus anticus tendon should be given a trial, since it is a much simpler procedure than removal of the rib.

Various methods of removing cervical ribs have been described, and all are necessarily tedious and difficult, but the operation can be performed without serious risk. To mobilize and remove a rib in one piece is unnecessarily hazardous from the standpoint of injury to the brachial plexus and subclavian vessels. For that reason we have always removed them piecemeal. The rib is partially uncovered where it can be easily reached, usually posterior to the brachial plexus, or between the upper and middle trunks, and then it is divided with rongeurs. The proximal end is stripped of its attachments, and using rongeurs with jaws no wider than the rib, the biting process is continued upward until disarticulation is accomplished. The same procedure is used on the distal segment until more than enough rib has been removed to allow the brachial plexus and subclavian artery to descend to their normal positions. Very little retraction is necessary, and for the most part the procedure is carried out under direct vision. We have removed ten ribs using this technique, and in no case was the brachial plexus injured or the pleura opened. The clinical results were entirely satisfactory in all cases.

Scalenus Syndrome

There is a group of patients in which the history and clinical findings suggest the presence of a cervical rib, and in which none is found by x-ray examination. For this group Naffziger and Grant¹³ applied the term "scalenus syndrome."

The lower trunk of the brachial plexus and the subclavian artery lie in the angle formed by the scalenus anticus muscle and the first rib. As with cervical ribs, symptoms do not appear until adult life; therefore, it is generally believed that alterations in posture, together with some abnormality of the first rib, is responsible for the syndrome.

When upper extremity pain is due to a taut scalenus anticus muscle there is marked tenderness to pressure at the base of the neck over the tendon of the muscle. Some patients are benefited by sleeping on their back with the head flexed so as to relax the scalenus anticus muscle. Others require tentotomy, which is the treatment of choice in most cases.

As the result of publications by Naffziger and Grant¹³, Ochsner, Gage and DeBakey¹⁴, Spurling¹⁵, and others, the importance of this syndrome has become established. We would like to point out, however, that the diagnosis of scalenus syndrome is less often made now than it was prior to our understanding of cervical disc lesions. Until a few years ago, many patients underwent tentotomy for what would be recognized today as a ruptured cervical disc, or intraforaminal osteoarthritis.

Summary

Upper extremity pain, usually limited to one side, is a very common complaint, and with the exception of local and obvious pathological conditions it is often caused by a ruptured cervical disc, arthritis of the cervical spine, a taut scalenus anticus muscle, or a cervical rib. The differential diagnosis and treatment of these conditions have been discussed.

Because of their proximity to the spinal cord, ruptured cervical discs are potentially dangerous, and should be removed without delay unless symptoms are abating.

Pain resulting from arthritis of the cervical spine may be relieved or greatly

diminished by halter traction, skeletal traction, or by unroofing cervical nerve roots, depending upon the extent of the disease.

Removal of a cervical rib is preferable to section of the scalenus anticus muscles if there is objective evidence of nerve injury and/or serious impairment of circulation in the extremity.

The scalenus syndrome assumes less importance as our understanding of pathological conditions in the cervical spine increases.

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Some Physiological Considerations in the Treatment of Patients With Congestive Heart Failure

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The invitation to take part in this meeting is an honor which I shall cherish all the rest of my life.

In the great majority of instances, symptoms arising from organic heart disease result either from disorders of the coronary arteries, or from congestive failure. It is with the latter group that this paper deals.

Almost any comprehensive definition of congestive heart failure might be subject to objection. A definition upon which at present most observers perhaps could agree, might be: a syndrome usually characterized by a large mass of slowly moving blood, an excessive amount of fluid in some of the interstitial spaces, associated with lessened renal blood flow, almost invariably with evidence of heart disease, and rather regularly with a cardiac output which is inadequate under the circumstances at hand. This discussion deals especially with cardiac oedema. It omits many important factors, concerning itself particularly with abnormal retention of water and salt. First however, I will ask you to review with me briefly certain data relating to the normal physiology of the body fluids. The economy of the body is a liquid economy, water comprising about 70% of the whole. There are three physiological divisions of this fluid.

The Intracellular Fluid: By far the greater part of body water is within the cells of the various tissues. This intracellular fluid constitutes about 50% of the total body weight, some 35 liters. The protoplasm of the individual cell is contained by a membrane which readily allows water to pass in either direction, the direction being determined by the relative osmotic tension within and without the cell. About 9/10th of the osmotic pressure of body fluids is maintained by electrolytes¹. Very recent experiments strongly support the long-standing thesis that the responsible electrolyte within the cell is calcium, this element giving substance to the protoplasm and to the membrane itself².

The Extracellular Fluid; (a) *The Interstitial Fluid:* It is obvious that cells so constituted must live in a liquid environment: The life-giving fluid of the body is not the blood. The blood is the life-bringing fluid, but it is this enveloping medium, the interstitial fluid, in intimate contact with the cells themselves, which gives them in solution the materials, upon which their very life depends. From them it receives in solution the products of their manufacture, delivering it into the vascular compartment for transport to other organs.

The electrolyte base in this interstitial fluid, which is mainly responsible for maintaining its proper osmotic pressure, is sodium, the normal concentration of which is about 3.3 grams per liter. Whatever variation may occur in the total amount of this element, or in the amount of the fluid itself, sodium concentration must not vary far from this normal. Otherwise transfer of too little or of too much water across the cell membrane would occur, with resulting injury to the cell.

The interstitial fluid is derived from the plasma of the blood. From the arterial ends of the capillaries it exudes into the interstitial compartment, carrying in solution its cargo of cell imports. Into the venous ends of those same capillaries it delivers to the blood the products of cell activity. The cell membranes and the capillaries thus form the boundaries of the interstitial compartment. Into all the remote recesses of the body this narrow lake sends its slender fingers, giving and receiving, transferring and replenishing, in never-ending duty. Normally it composes about 15% of body weight, some 10½ liters.

(b) *The Intravascular Fluid:* Rapidity of transportation requires that a portion of the extracellular fluid, the blood plasma, be enclosed in a specially constructed compartment, the vascular system. The total amount of plasma normally is some 3½ liters; the addition of about 1½ liters of cells bringing the total blood volume to a normal amount of some 5 liters.

The sodium concentration in this intravascular fluid (plasma), which diffuses

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readily into the interstitial compartment across the arterial capillary wall, and which receives fluid from it by constant diffusion across the venous capillaries, normally must be about the same as that in the interstitial fluid, 3.3 grams per liter. The total amount of sodium in the two compartments of the extracellular fluid thus averages about 46 grams. It is said, however, that in the constant diffusion of fluid back and forth across the walls of the hundreds of millions of capillaries in the body, some 50 pounds of sodium chloride diffuse daily; approximately 20 barrels of water passing between the blood vessels and the interstitial spaces every day³. Like our primordial ancestors we live in salt water.

The maintenance of normal sodium concentration in the plasma, and its identity with that in the interstitial fluid, is accomplished by the kidneys⁴. In considering this aspect of kidney function, it is necessary to keep in mind the tremendous volume of the normal circulation.

Normal Cardiac Output: Under normal basal conditions with each beat the left ventricle ejects into the aorta about 62 ccs. of blood, the same amount going from the right ventricle into the pulmonary artery. In one minute, 60 or 70 times this amount, some 4 liters, nearly the entire volume of blood, has been utilized on each side of the system. In 24 hours the heart has repeated this minute output so many times that each ventricle has moved about 6000 liters; some 40 or 50 barrels of blood.

The Regulation of Sodium Concentration by the Kidneys: Normally about $\frac{1}{4}$ of the total cardiac output goes through the kidneys. Through the 2,000,000 and more glomerular tufts of these organs pass 1200 or 1300 ccs. of blood per minute; 10 barrels of blood and more per day. Of this tremendous volume some 6 barrels is plasma, and from this there is filtered through the capsules of the glomeruli, with their square meter of filtration surface, something like 123 ccs. of fluid per minute; 179 liters, (or more than a barrel), of fluid a day. As this great mass of fluid winds through the tubules, most of it is reabsorbed; only about a liter and a half per day being expelled as urine.

The reabsorption of fluid and of sodium by the kidney tubules is a process which long has received the careful study of many investigators. Much is known about it, much remains to be discovered.

Whatever the precise mechanism, however it may be mediated, the kidney, "the organ par excellence of evolution," by precise adjustment in the excretion and reabsorption of water and of sodium, keeps the concentration of plasma sodium at its normal level¹. It is obvious that, in maintaining the normal plasma ratio of water to sodium, the handling of one of these substances in the kidney involves appropriate adjustment of the other. Too little or too much sodium in the plasma, for example, necessitates corresponding decrease or increase in water. Most authorities have appeared to think this function of the kidney relates primarily to the control of sodium; the adjustment of water being a secondary consequence to the correct handling of sodium. Thus it has been customary to explain the increase in extracellular fluid that generally characterizes congestive failure, as due to a failure of the kidney primarily to eliminate sodium in normal fashion; the resulting sodium retention necessitating a corresponding retention of water. Some careful studies⁵ recently published, however, indicate that the impairment of kidney function responsible for oedema is primarily a defect in the elimination of water; sodium retention necessarily following water accumulation. However the matter may be, in congestive failure the increase in interstitial fluid (oedema) is attributed largely to impairment of kidney function. This failure of the kidney normally to eliminate water and sodium appears now to result from diminished circulation in the kidney.

Renal Ischemia: Recent research has shown that in chronic congestive failure with oedema there is a greater or less degree of renal ischemia. The circulation in the kidney is extremely complex. Trueta⁶ and his co-workers have presented strong evidence indicating that upon occasion much or most of the kidney blood flow may be diverted away from the cortex and shunted through the medullary pathways. Since it is in the cortex that the bulk of the active glomeruli are located, such a shunt obviously would lessen glomerular filtration. Trueta finds that the loops of the tubules especially concerned with fluid reabsorption are located principally in the medulla. Diversion of blood to this area thus would promote reabsorption. It must be noted, however, that in congestive failure, such a diversion has not been demonstrated, even though renal ischemia from some cause exists.

Whether it results simply from diminished supply from the heart, as Merrill^{7,8} suggests it may, or from a shunting of blood away from the glomeruli, (a factor not denied by Merrill), by constriction of the efferent glomerular arterioles or other mechanism; or whether it is mediated at least in part by abnormal function of endocrine glands; at present perhaps cannot surely be determined. Whatever may be the precise mechanism, however, renal ischemia appears to be intimately related to the retention of sodium and water. Merrill and others have related sodium retention to the decrease in filtration rate, which is known to occur in congestive failure. When this falls (from the usual normal of 123 ccs.) below a critical level of 70-80 ccs. per minute, oedema forms; less sodium being filtered, less being eliminated, more being retained. Others have found evidence of abnormally increased reabsorption of sodium from the filtrate back into the plasma. In summary, Smith⁹ says that the renal circulation and the endocrine control of sodium excretion appear normally to be coordinated in the maintenance of a normal volume of extracellular fluid. In congestive failure he thinks this coordination has broken down; resulting in renal ischemia, perhaps increased sodium reabsorption, certainly in sodium and water retention.

Diminished Cardiac Output in Congestive Failure: In their preoccupation with the great immediate importance of sodium, for a time there were those who apparently were willing to leave the heart out of congestive heart failure. Now, however, it is generally agreed that in this syndrome cardiac output regularly is less than the requirements of certain vital organs; and that whatever may be the immediate cause of the renal ischemia with its accompanying defect in fluid and sodium excretion, this defect in kidney function is to be referred ultimately to inadequate cardiac output. When one keeps in mind the enormous flow of blood required by the various vital organs for normal function, it is easy to understand that serious consequences in the function of the adrenals, the posterior pituitary, and of the kidney itself, may follow any diminution of the circulation below a level that may be critical for the circumstances of the moment. We have noted that some 10 barrels of blood normally go through the kidneys daily. In congestive failure the kidneys may find that they now receive only 6 barrels. Instead of

the glomeruli filtering 179 liters of fluid, they may be able to send down the tubules only 108 liters. Less fluid and less sodium, therefore, are eliminated; more are retained; oedema forms. An amount of kidney blood flow below the critical quantity would appear to produce oedema, whether or not there were some additional factor causing increased reabsorption of sodium.

Restriction of ventricular output with consequent sodium and fluid retention may result from quite different situations. (a) If inflow into the ventricle is abnormally diminished, as for example, in high grade mitral stenosis or in constrictive pericarditis, output must correspondingly be diminished, even though the musculature of the ventricle be unimpaired. (b) Myocardial disease may render the ventricle unable to deliver the blood it receives. In the vast majority of cases of congestive heart failure, inadequacy of output results from such impairment of muscular function. This impairment may rest primarily in either ventricle, the weaker chamber determining the output of both. When the over-all minute output of one side of the heart falls, the amount of blood delivered per minute to the other side necessarily is diminished; and, since the stronger ventricle obviously can eject only what it receives, its output soon must fall correspondingly. A disproportionate amount of blood may remain on one side or the other, but the quantities that move from one side to the other, over any considerable period of time, must remain equal.

Under various circumstances of health the cardiac output may be considerably above the average basal amount of some 62 ccs. of blood per beat. It may become augmented also as a physiological response to the increased requirements incident to certain disease states, e. g. anaemia, exophthalmic goitre. Conversely, in certain abnormal situations, myxoedema for example, lessened tissue requirements may lower output below the usual basal level. Whatever may be the attendant circumstances, however, whenever the heart long is unable to deliver to the tissues an amount of blood adequate for those circumstances, certain organs suffer in greater or less degree. The kidney suffers early¹⁰.

Therapy: Many abnormal results follow critical diminution of ventricular output. One of them is the formation of

oedema. The objective of therapy regularly should relate not primarily to removal of the results of impaired function, but to removal of the cause. In congestive heart failure the prime objective of therapy should be, not the removal of oedema, but should be the restoration of impaired ventricular function; to increase ventricular output. It is with this objective that digitalis is employed.

With cardiac catheterization more precise measurements of ventricular output now are available, and much of the earlier confusion regarding the diminution of output with congestive failure, and its improvement under digitalis, has been cleared up. Stead¹¹ and his co-workers administered lanatoside C intravenously in 22 cases of congestive failure. In 18, the average increase in cardiac output was 1.6 liters per minute, 575 gallons per 24 hours. Bloomfield¹² and his associates administered ouabain directly into the heart, finding that it acts directly on the failing heart "by increasing its stroke output." Harvey¹³ and others gave digoxin in 5 cases of left ventricular failure, finding "a significant rise in cardiac output" in each case. The conception long entertained that digitalis exerts some action directly on the ventricular muscle by virtue of which in congestive failure it increases output, can no longer be subject to question. There is some evidence also that it may have in addition a diuretic action directly on the kidney tubules¹⁴, or an action which in some way lowers renal venous pressure¹³. In the cases of many patients with congestive heart failure, under no change in usual sodium intake, and with no other diuretic, the administration of digitalis improves ventricular function to such a degree that output rises well above the critical level, and the evidences of inadequate output no longer are present; symptoms disappear; oedema is eliminated: the objective of therapy is achieved and maintained. In the case of one patient, with normal rhythm, rate 80, who had received no recent digitalis, whose salt intake was not restricted, and who received no other diuretic, the administration of a therapeutic dose over a period of 10 hours resulted in no change in rate, but in a conspicuous diuresis with loss of 10 lbs. in 24 hours, and an additional 8 lbs. the next day¹⁵. Another patient after a single dose of digitalis put out 5000 ccs. of urine in 24 hours, with loss of 10½ lbs. of weight the first day, and 12

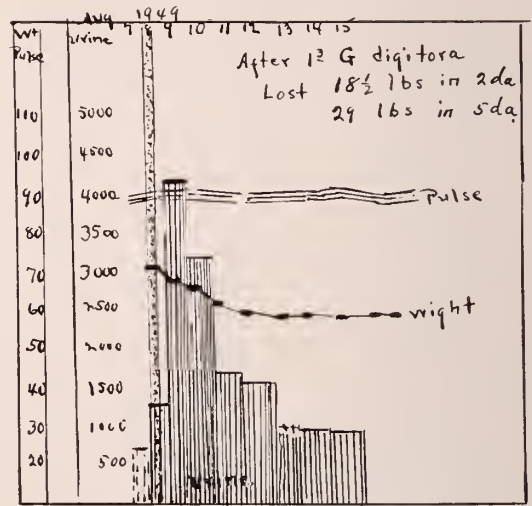


Figure 1

lbs. the next day¹⁵. In the case of a third patient, (Fig. 1), after 1.3 G of whole leaf, there was a loss of 18½ lbs. in 2 days, 29 lbs. in 5 days.

In many cases, however, myocardial damage has been so great that neither digitalis nor any other known therapeutic agent can restore cardiac output to adequate levels. In such cases, as in other common medical and surgical situations, in order to compensate for a given abnormal situation, recourse properly may be taken in certain measures directed not primarily toward removal of the cause, and which themselves under normal circumstances would be unphysiological. Various such measures frequently are helpful. Limitation of the amount of sodium available for entry into the plasma, by tending to lower its plasma concentration, may cause the excessive amount in the interstitial fluid to re-enter the capillaries, withdrawing excess fluid along with it; both being eliminated by the kidneys. This often can be accomplished, either by restricting sodium chloride in the diet, or—while allowing the patient to eat his usual amount of salt,—by giving him at the same time a quantity of ion exchange resin sufficient to prevent the absorption of sodium chloride from the gastrointestinal tract; causing its elimination in the feces. Or, mercurial diuretics may be administered, so as to interfere with the reabsorption of sodium chloride and water by the kidney tubules, thus causing their elimination in the urine. In the case of a woman weighing 121 lbs., with mitral stenosis, whose oedema appeared to result from insufficient inflow of blood into

the ventricle, the administration of 2 ccs. of mercurhydrin resulted in a loss of 9 lbs. in one day, 20½ lbs. in 5 days.

The fact that some 46 grams of sodium are necessary for the proper electrolyte content of the extracellular fluid must be kept in mind. The frequent employment over a considerable period of time of any therapeutic procedures which cause elimination of sodium greater in amount than that which is taken into the body involves the risk of serious sodium depletion. Soloff¹⁶, Schroeder¹⁷, and many others have emphasized this danger.

The hazards of over digitalization also repeatedly have been emphasized. In two particular situations this danger might well be mentioned again. *First*: In the cases of patients whose myocardial function is beyond restoration to normal. The physician's enthusiastic desire to obtain the very highest possible degree of the therapeutic action of digitalis may lead him to administer toxic dosage, unless he constantly keeps in mind the impossibility of determining precisely that level at which intoxication may begin.

Second: In the cases of patients whose myocardial insufficiency is due to coronary disease and who may have had angina prior to the onset of congestive failure, the very relief of congestion afforded by digitalis, or by mercurials, may itself produce again the condition in heart muscle which favors the return of the anginal syndrome. In congestive failure the volume of blood tends to be increased. This increase would appear to apply also to the myocardium. Angina results from the opposite situation; from myocardial ischemia of greater or less degree. Whatever may be the explanation, the conception of a certain incompatibility between anginal failure and congestive failure has been emphasized over a long period of time^{18, 19, 20}. In treating a patient with congestive failure, who recently has had angina, by whatever means the physician may try to relieve this congestion, not infrequently he finds himself between the

devil of cardiac pain and the deep blue sea of congestive failure.

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The Use of Excision of the Head in the Treatment of Fractures of the Neck of the Femur

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As the physician in general practice sees the patient first he should know the prognosis in fractures of the neck of the femur. The operative treatment is done by the surgeon.

Bony union does not occur in one hundred percent of the cases. By the many methods of internal fixation the percentage of union has risen above that of traction or plaster immobilization. We still have 16-20% non-union.

The fracture is painful. The non-union is painful.

The treatment of the "fracture of the neck of the femur" varies with the type of fracture that occurs. There are transverse cervical fractures, oblique or vertical fractures, base neck fractures, and comminuted fractures of the neck of the femur.

The bony repair in our cases has decreased rapidly when the patient was over eighty years of age. The osseous system has undergone degenerative changes with loss of lime salts and vascularity of the bone. The articular cartilage of the head of the femur is grey, fibrillated and in spots free of the head. With the cartilage degeneration and vascularity decreased—how can one expect osseous union in the fracture?

In the large hospital there are patients admitted who have been bed ridden for a long time; physically incapacitated so that they are able only to go from bed to chair, or partially paralyzed from hemiplegia. When these patients receive a fracture of the neck of the femur, can they be rehabilitated? They were unable to take care of themselves before the injury—how can fixation of the fracture restore them to usefulness?

In these patients why not do a simple

operative procedure? Why not a treatment that relieves the pain? Why not a treatment that makes for a short hospitalization and easy care of the patient?

We wish to suggest doing a procedure that is simple and easy for treatment of fracture of neck of the femur in the aged and debilitated.

This treatment is excision of the head. Pain is relieved. Convalescence is short. Hospitalization is a minimum.

There is shortening of one and half inches plus. The extremity is unstable and flail. In certain individuals ambulation is possible with an elevated shoe and crutches or cane. Gait is similar to that of an unreduced congenital hip.

The head is excised through a lateral approach as described by McMurray. The operation is of short duration and not shocking to the patient. A plaster boot with a horizontal bar is used for seven days to prevent external rotation. No attempt is made to place the remaining portion of the neck in the acetabulum.

The patient now has no fracture. The operative pain is soon relieved. There is no long convalescence. There is no fear of a non-union that is painful.

We have used this procedure in selected aged patients, those patients with general debilitated status, and those with invalid state from other causes, with success.

An easy solution for treatment of the fracture of the neck of the femur in the aged is suggested.

A movie was shown of four patients that have been operated upon.

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Special Article

Golden Spikes

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Louisville

One hundred years ago our country was confronted with two major problems; the questions of slavery and transportation. The prolonged and bitter dissensions eventually leading to war and the tragic after-years that intervened before our nation was again truly unified are known only too well by all. Our population then was 23,000,000. Expansion by sea and overland trail had spread these Americans thinly from coast to coast, and from the sparsely settled Canadian border to the Gulf and the Rio Grande. The industrial East with its rapidly growing factories and railways was separated from the sprawling and fabulously rich West with its mining and railways by the Rocky Mountain barrier over which commerce dribbled in snail-like fashion by mule train and covered wagon. San Francisco was, by sea 30 days voyage from New York—via Cape Horn, an expensive and treacherous passage.

Practical dreamers, buccaneering industrialists, ingenious Yankees and western pioneers in true American fashion counselled and connived with the master politicians of the day and came forth with a vision of a transcontinental railroad. The realization of this dream is one of the most fascinating and romantic chapters in our history. To T. D. Judah, a young civil engineer in California, and Dr. Thomas Durant, a restless young physician of New York turned to railroad construction, belong most of the credit for personally forwarding the endeavors leading to accomplishment of this plan. An Act of Congress was signed by President Lincoln in the latter part of 1862, authorizing the construction of a transcontinental railroad by the Union Pacific Railroad Company of New York and the Central Pacific of California. Civil war was then in progress. Dr. Durant devoted his time to the Union Army as a

military surgeon, and surveys and construction were delayed. The American people had caught the vision of industrial development dependent upon improved transportation, however, and with the cessation of hostilities on the battlefield turned quickly to peace time development and a united nation.

Intrigue and treachery, boondoggling, waste and embezzlement on a scale thus far unknown were combined with courage, privation and dauntless devotion to service. Personal dissention disrupted their leaders, unfaithful trusteeship and biased judgment depleted their treasuries and political pressures led their surveys along impossible routes only to be abandoned at huge cost of money and time; but to a few there was no thought of faltering or abandoning their vision. The Union Pacific with its 10,000 Irish laborers sped by rapid miles across the plain and crawled painfully foot by foot over canyons and beneath mountains in a race against time with the Central Pacific whose 12,000 Chinese coolies traversed the arid deserts of California and the impenetrable western Rockies.

There came a day, on May 10, 1869, when the rails from the East met those of the West at Promontory Point, Utah. The entire nation awaited the historic moment. The telegraph ticked off the minute by minute progress to assembled crowds in holiday celebration at New York, San Francisco, Chicago, New Orleans, and cities the country over. The Union Pacific's locomotive, "Old 119," faced the Central's "Jupiter," puffing smoke and hissing steam. Governor Leland Stanford of California faced Dr. Thomas C. Durant of New York across the rails. Each wielded a silver hammer. Montana, Idaho, California, and Nevada provided each a spike, two of silver and two of gold, which driven into a tie of polished California laurel completed a dream of progress and united the East with the West.

Presidential Address delivered at the Centennial Banquet of the Ephraim McDowell Memorial Meeting, the Centennial of the Kentucky State Medical Association, Louisville, October 2-5, 1951.

Transportation since that day has moved forward at an ever increasing speed. The original road at its point of union has long since been abandoned and there remains now only a trackless grade over which our first transcontinental trains so proudly sped. Eight other transcontinental lines carry passengers and express with greater comfort and speed and in volume multiplied a thousand times. Airlines have dwarfed the proud schedules of the railways and our 150 million people traverse the continent as they would commute to work. A simple pyramid still stands at Promontory Point describing for those who care the historic accomplishment of that far off day. The achievement of those indomitable men who contributed so significantly to our national progress shall forever be monumental in our annals. The Golden Spike remains a symbol in American history.

One might believe that a century of growth with industrial expansion and education would lead to a simpler, more direct and economical solution of our problems than our ancestors were able to find. Progress remains slow and tedious, however, to our present day. Conflicting ideals and objectives, divergent personalities and opinions must be harmonized and brought into a forward direction. Time and wasteful expenditure is required in such a process. But this is the American Way—the best and most progressive on earth.

When the history of the past two decades is written there will perhaps be brought into clear relief a tremendous surge toward socialization—a trend of the times contrary to our American tradition. Standing directly athwart the path of this moving tide and threatened with engulfment has been the medical profession. Differing in our own opinions, and apparently too small a minority to successfully resist the powerful political pressures brought against us, our position for a long time seemed hopeless. There were those alert and courageous statesmen of medicine, however, who sounded a loud and persistent alarm and began to unify our opposition to this doctrine. At the eleventh hour did we fully realize our peril and resist as a strong, belligerent body of Americans. Help came from those about us who gradually learned that our danger was also their own. Thus, we have been able to turn back the first wave of assault by those who would change and de-

stroy our traditional American Life. It seems now very probable that this heroic stand made by our profession and its friends has not only won the admiration of Americans everywhere but may well mark a turning point in the trend of events away from the socialized state and back toward individual enterprise for our entire economy.

And let us pause here long enough to pay tribute to two Kentucky physician-statesmen. Most Kentuckians feel that during the last twenty years of his brilliant and fruitful life, Dr. Irvin Abell exerted a more beneficial and sustained influence for good on American medicine than any other single person—and this opinion has been frequently expressed by physicians in distant states. Those of us who had the privilege of knowing him intimately as a neighbor and friend will always hold him in the highest and most affectionate esteem for his constructive contributions. When, two years ago, he laid down his work the torch which he had carried with such distinction for so long was passed to the hands of another Kentuckian. At great personal sacrifice during the past five years he has spared neither his health and comfort, nor time nor financial means. In every state in the union and lands abroad he has waged a ceaseless campaign. He has cried from the housetops to awaken our profession. Personal friendships in high places have been sacrificed and he has borne without complaint storms of individual criticism and censure. No physician has been more loyal to his ideals and to his profession nor served it better than has the recent President of the American Medical Association, Dr. E. L. Henderson, and to no one man is more due the reward of achievement.

We have stood upon the principle that the practice of our profession unhampered by government regimentation is a sacred American right. We have shown that achievement of the highest standard of health on earth for our people has been and will continue to be best accomplished by the survival of our system of individual initiative. We affirm that the education of doctors is the concern of the people and of the respective states and not an agency of the Federal Government. We have driven a golden spike to connect the historic past with a future of brilliant promise. It may be that we stand today where our road turns away from the social

state to safer country. It is our profession's finest hour.

The medical profession is the one agency in the most favorable position to know the problems of health affecting the people and must outline and blueprint the best plans to follow. Individuals, states, and countries spend their money for the things they most want. It is our responsibility to understand and propose honestly and clearly to our citizens and legislators what things in health should and can be afforded for the greatest welfare and with the best economy.

My predecessors in this office have, in recent years, with the guidance and help of our Commissioner of Health and the Council sought to understand clearly the problems affecting the health of our people and to find practical solutions for them. Kentucky is not a pauper state but it is poor in respect to taxable properties and per capita income with a position of 44th among our 48 states. Money must therefore be spent wisely and our health programs built on modest and efficient patterns. Profligate and ill-advised spending on one project will deprive of development others equally essential.

The Kentucky State Medical Association has now three broad objectives, the accomplishment of which seem most urgent and immediately necessary for the welfare of our people. The first is the improvement and expansion of its Public Health activities; the second, better care of our indigent sick; and the third, expansion of medical education. The first two of these have long held priority in the plans of our Health Commissioner who is, with the help of the Council, initiating practical outlines for their solution. I shall discuss them very briefly. With the third I have principally concerned myself during the past two years and shall discuss it in somewhat greater detail.

Economic pressures of the past decade, scarcity of available trained personnel and salary limitations have put our traditionally fine Public Health Program under the severest strain. Existing County units have required the strictest economy and cutbacks in operation until they are now in real jeopardy. The opening of new full time units in counties most needful and desirous of them has become well nigh impossible. The Governor, in his sympathetic attitude toward health and a full appreciation of the need, has

been most cooperative and this year has appropriated emergency funds to this purpose. A wider and more secure base is being sought and will be obtained and this essential feature in medical care will receive the attention it so urgently needs.

There are many counties whose taxation base is so inadequate and whose indigent population is so large that they cannot provide for the care of their sick. These counties require aid from the state at large. Funds from the state must be found to supplement the barest necessary care in those areas. Doctors, where at all available, have always and will continue to provide their services to these indigent sick but they cannot give hospitalization, even where most urgently needed, nor medication, nursing care and the basic essentials of health. We feel it our responsibility as physicians to present to the fiscal courts concerned and to our legislature the practical means by which this pressing need can and will be met.

Kentucky is in need of more physicians. In the United States as a whole there is one physician to 740 people—in Kentucky there is one to 1100, and these are poorly distributed. There are 7 counties with an average population of 7,000 with 1 physician each, and 12 counties with a total population of 96,000 served by only 17 physicians, one doctor per 6,000 people. The Kansas plan for better distribution of doctors, under the leadership of Dean Murphy, has received wide publicity and acclaim. Similar methods have been practiced in Kentucky since the end of the recent war and with encouraging results. Distribution of the new general hospitals under the Hill-Burton Plan, the building of health units and small clinics now under consideration and the establishment of rural scholarships have already affected this situation very favorably. Continuation and extension of these measures will accomplish a more and more equitable distribution of our physicians to the rural portions of the state.

One reason why we do not have a sufficient number of doctors is that we do not have the facilities for educating them. The University of Louisville School of Medicine, as is true in practically every one of the 72 medical schools in the country, is enrolling every student for whom it can possibly provide facilities of study—a total of 100 in the present freshman class. The freshman class of medical students in the United States for 1950, totalled

7187. Kentucky has 2% of the national population and our proportion of freshman medical students, therefore, should be 140 instead of 100 and we should have graduated 120 instead of 90 of the 6000 medical graduates of last year.

There are adequate numbers of men in Kentucky qualified for and desirous of studying medicine but we do not have the facilities for their education. In 1949, the latest year for which complete statistics were available, there were 4.8 freshman students per 100,000 population for the country at large—of Kentuckians there were 4.6 freshman medical students per 100,000 population but a large percentage of these students sought and found opportunities to enter medical schools outside of Kentucky because we could not accept them. Of these men studying medicine outside the state many do not return to practice. It would appear that if we are ever to have an adequate supply of doctors for practice within the state we must provide facilities for their education.

The American Medical Association through its Council (on Medical Education) has offered plans since 1910, which have revolutionized medical education in the United States. With reduction in the number of schools and elevation of entrance requirements combined with the effects of the first World War there were only 2304 physicians graduated in 1922, which was the low year for the first half of this century. That depression was only temporary, however, and by 1930, the national output was 4565, in 1940 it was 5097, and in 1950 it was 5553. During the past 20 years, since 1930, while our national population has increased by 14% our yearly number of medical graduates has increased by 21%. In the decade from 1950-60 it is planned to increase by 30% our national annual output of physicians. That is a highly desirable and necessary goal, but it cannot be accomplished unless the existing 72 schools run to full capacity and wherever possible expand their present facilities. Also some new schools are being planned and will undoubtedly be placed in operation during this decade.

With a view toward finding the best solution to this problem for Kentucky the Dean of the Medical School, the Commissioner of Health, and I undertook, early in the year, to gather data and competent advice on our local situation. The secretary and associate secretary of the Coun-

cil on Medical Education of the American Medical Association spent April 17-18 here and in Lexington making a careful survey of the clinical facilities in each city and from their experience with the same problem elsewhere gave us a complete and most encouraging report. They advised the establishment of a new four year school at Lexington as the most adequate and permanent solution and they furnished very encouraging figures to indicate that the cost of this plan is within reach of our state's finances. An alternate plan recommended was expansion of facilities at the University of Louisville School of Medicine so that we may enter 140 freshmen each year instead of 100 and graduate 125 per year instead of the present 90. This increase would meet our needs at least during the next ten years.

With this data and recommendations in hand and with the associate secretary of the Council on Medical Education in attendance we had a meeting of the Council of the Kentucky State Medical Association on May 30, and again on August 29, devoting the entire days to a consideration of this problem. It was felt by almost every member of the Council that the alternate plan, that is, the expansion of the school at Louisville is the most practical solution for the present because of two principal reasons: this can be accomplished in a much shorter period of time and an increased number of physicians be put into practice when we are urgently in need of them; with our limited resources it is more practical to maintain one exceptionally strong school within the state than to try to maintain two, under constant financial handicap. Our position in this matter is further strengthened by assurance by those most conversant with the state's finances that now, during the Korean Crisis, money is not and will not be available for the state to launch a new medical school even on the moderate basis of cost outlined by recent studies. There is no thought in any instance of lowering our standards or the quality of medical education furnished but rather to strengthen it. The 72 medical schools now in operation in the United States are all A grade. Since 3 years ago when the last of B grade medical schools were either closed or brought to A grade there are not and should never again be schools of substandard rating.

We as a Council on behalf of the State

(Continued on p. 487)

The JOURNAL *of the* Kentucky State Medical Association

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	Term Expires
J. Duffy Hancock, 704 Brown Building, Louisville.....	1952
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	Term Expires
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Sixth District	L. O. Toomey, Bowling Green..... 1954
Seventh District	Branham B. Baughman, Frankfort..... 1953
Eighth District	Edward B. Mersch, 92 Arcadia, Covington..... 1954
Ninth District	J. R. Cummings, Flemingsburg..... 1953
Tenth District	J. Farra Van Meter, 183 N. Upper Street, Lexington..... 1952
Eleventh District	Hugh Mahaffey, Richmond..... 1953
Twelfth District	Carl Norfleet, Somerset..... 1953
Thirteenth District	Clyde C. Sparks, Mayo Arcade, Ashland, Chairman..... 1953
Fourteenth District	Paul B. Hall, Paintsville..... 1953
Fifteenth District	Edward Wilson, Pineville..... 1954

ANNUAL MEETING REFLECTS INTENSE WORK OF COMMITTEES AND OFFICERS

The annual meeting held during the first year of the second century in the life of the Association will go into the records as one of the best routine meetings in the Association's history and with one of the largest attendances on record. Approximately 36 per cent of the membership registered, which is considerably above the average attendance at state medical meetings.

The 1952 scientific programs, which had been so carefully arranged, vindicated the judgment of the Committee on Scientific Assembly. For the most part, the program, well-balanced, was well attended and received.

Addresses at the public meeting, the president's luncheon and the annual dinner were all outstanding, thought-provoking, and most profitable. The one dark spot in the entire meeting was the un-

fortunately small attendance at the public meeting.

The scientific exhibits were excellent. Much interest was shown in the scientific movies. The technical exhibits were very good and made their usual important dual contribution to the meeting.

Few realize the tremendous amount of time, thought, and effort that the president and all of the committees charged with mounting an annual meeting expended in developing the yearly session. Certainly, the Association owes a deep and lasting debt of gratitude to the retiring president, the Committee on Arrangements, the Committee on Scientific Assembly, the Committees on Scientific and Technical Exhibits, and the various sub-committees that made your 1952 meeting the outstanding success it was.

PRESCRIPTION FOR PROGRESS

The secretary is the corner-stone of the county medical society. We may well go a step further and say that he and his contemporaries in county medical societies all over the country are the corner-stone of organized medicine in this country. Many feel that the society is no better than its secretary.

The importance of keeping the records, handling the correspondence, bringing old and new business to the society's attention cannot be over-estimated. The secretary keeps up with the committee work, makes sure the program is arranged, sees that the society's activities get proper publicity, serves as spokesman for the society, and acts as the connecting link between the county, state, and national medical associations.

The good county society secretary is a man respected by both the profession and the community in which he practices. He is a man of judgment, ability, and character. He has at heart the welfare of his fellow practitioners and of the people they serve. His position in the profession is one of dignity and leadership, making him a leading citizen in the community.

Some observers feel that there is a great popular ignorance among members of the county medical societies of the real importance and true functions of the secretary. This is demonstrated year after year by the lack of thought shown by the county organizations in choosing a secretary. These practices are so well known it is not necessary to comment on them here.

The officers and councilors of your state association have given deep and serious consideration to this matter. They feel that the county society secretary is the key figure in the whole structure of organized medicine, that great care and thought should be given his selection, and once elected, he should receive support and co-operation.

Because your officers and councilors feel this way, they asked the House of Delegates to endorse the principle of not electing a member of the county society to the secretaryship until he has been a member for two consecutive years and that he be chosen for a three-year term. The House gave its whole-hearted approval to this resolution, which is not

binding on the county societies but focuses attention on the high importance of this office and pin-points the responsibility of the counties in this matter.

Every thinking physician knows the medical profession has a long hard fight ahead of it. Before this editorial is printed, the results of the national election will be known. But, regardless of the outcome, the long conflict is still ahead. The

fight will be won or lost at the county level.

We are approaching the season of the year when the county societies will be electing their new officers. Your officers and councilors urge your earnest and careful consideration of the all-important matter of selecting strong leadership for the new year.

SIGNIFICANT SIGNPOSTS

There are a number of significant developments in the new 1952-53 association year which started October 10, the day after the annual meeting closed, and which indicate progress, seriousness of purpose, and fruit-bearing efforts on the part of the members of the association.

The new President, R. Haynes Barr, M. D., announced the committee appointments for the new year that he had made after consultation with the Secretary and General Manager, Bruce Underwood, M. D. At the same time, Clyde Sparks, M. D., chairman of the Council, announced the personnel of the committees the Council is responsible for, which were chosen by it at the reorganization meeting, October 9.

In the Organization Section of this issue of the Journal the 1952-53 committee personnel, named by both appointing authorities, are listed. There are 52 committees with 448 names. Last year there were 42 committees with 263 names. In the memories of some veteran observers, the committee roster for the new year has never been filled so promptly nor has it been so large.

The President pointed out advantages to naming the committee personnel at the earliest possible time, thus reducing the "lag" in committee work which usually

accompanies the start of a new association year. By increasing the number of working groups and giving each the maximum number of appointees, the President stated the operating base of the association was being broadened, new leadership developed, and more young, carefully selected men would receive experience.

Another noteworthy development is the committee activity that was immediately scheduled following the announcement of new appointments. Ordinarily, there is little or no committee work done until after January 1, each year. This time, except during the American Medical Association meeting early in December, at least one meeting was set for each week during November and December. In some weeks, two or three sessions were planned.

When it is realized that members travel more than a total of a thousand miles for the average committee meeting, that these efforts are strictly a "labor of love," that it costs each man to be away from his office, and that none of his travel expenses are paid by the association, it must be concluded that continuing progress is ahead for the physicians of Kentucky and, more important, for the patients they serve.

GOLDEN SPIKES

(Continued from p. 484)

Medical Association will continue to endorse and press in every way possible for this as the most practical present solution of our problem. Should further study establish that a new and separate medical school at Lexington is feasible and practical and that Kentucky will be able to support both institutions adequately we will gladly accede to the change. But the

need for expansion is plain and urgent. Our responsibility as a state is clear. Now would appear to be the appropriate time for decisive action. On the long road of medical progress which has sometimes been slow and tedious and sometimes has moved with speed and brilliance let us drive here yet another golden spike which will declare forever to our citizens and to our posterity that we have served them well.

President's Page

The Kentucky State Medical Association has completed a successful year marked by great accomplishments under the able and inspiring leadership of Dr. Clark Bailey of Harlan, whose tenure of office came to a brilliant close with his profound and eloquent address at the annual dinner. His leadership was further demonstrated by the remarkable registration at our annual meeting and by the size of the intently interested audience, which filled the auditorium during every session of the scientific program. The Kentucky State Medical Association has come far, but you will agree with me I am sure that we still have heights to scale, new worlds to conquer, and new goals to achieve.

One cannot sit through the proceedings of the House of Delegates and watch the enormous amount of business discussed so orderly and intelligently without feeling a great pride in such a democratic organization. It is impossible to listen to the reports of committees and officers and to realize the great amount of time and effort which have gone into them without having a feeling of security in the future of medicine in Kentucky.

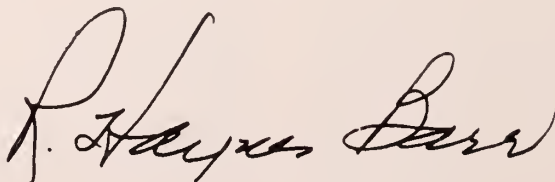
It is encouraging to note the broadening of individual participation in the affairs of our association. This is a very healthful omen. No one can get much from his Association unless he puts a corresponding amount of effort, thought, and time into it. The true function of your officers is to translate into appropriate action the collective thinking of the majority of the individual members, and I shall always bear this in mind during the coming year.

Through the medium of this monthly President's Page I should like to discuss with the members of our Association the various problems which confront us, the

long-range working program of our Association, and the almost incredible amount of work done at times by our various committees. I would be pleased if individual members would write their officers and furnish them with any constructive criticism in regard to administration, aims, functions, or programs which they would like to see changed in any respect. I have every confidence that all such suggestions would be considered seriously, and where any degree of unanimity exists, would immediately be put into effect.

Committee assignments for the coming year are completed. Since the lion's share of our Association's accomplishments can be attributed to the industry and zeal of our many important committees, I felt speed in their appointment would better enable them to do their work over the full 12 months. In some instances, where vital projects were unfinished, the same committee chairmen have been asked to serve another year. In other cases, where chairmen have given generously of their time for several years, it was felt only fair that they be given some relief, and members of their committees have been stepped up to chairmanship. A serious effort has been made in every committee to feed in several younger men whom officers and councilors thought to be men of potential ability. This appears to have the advantages, first, of broadening the base of membership participation in management of the Association, and second, of assuring experienced leaders for the years to come.

May I again remind you of the need of your support, your advice, and your suggestions, without which your officers can accomplish little.



PRESIDENT

ORGANIZATION SECTION

Societies to See Lantern Slides During Telephone Seminars

Lantern slides will be sent to subscribing county societies for the Association's 1953 telephone seminars, January 27, February 24, March 31, and April 28, Robert Lich, Jr., M. D., Louisville, chairman of the committee on medical education, announced.

In addition to the slides a manual and other visual aids like those used in last year's seminars will again be provided to the subscribing societies before each program. The slides, some of them in color, will be flashed on the screens in the local county society meeting rooms at the indicated time and will be discussed by the panelists, Dr. Lich stated.

A big advantage of the telephone postgraduate series is that it brings the latest and most significant developments in medical science right into the local meeting rooms of the societies at an unbelievably small cost. Members of the subscribing societies can hear top talent without having to travel great distances to medical centers, thus saving time and money and obviating inconvenience to their patients, the chairman pointed out.

The committee is preparing information giving full details of the 1953 seminars which will be sent this month to all county medical society secretaries.

AMA Plans Video Amphitheatre, Dec. 2 Clinical Session

TV will play a big part in the Sixth Annual Clinical Session of the American Medical Association at Denver, December 2 to 5, with the telecasting of three programs from operating rooms at Denver General Hospital, and color presentations of both a cardiac program and symposia on jaundice and peptic ulcer.

The Kentucky State Medical Association will be officially represented by its delegates, J. Duffy Hancock, M. D., president, and Bruce Underwood, M. D., secretary and general manager.

The General Practitioner of the Year will be named by the Board of Trustees after selection from a nation-wide list of nominees submitted by county and state medical societies. Over 200 papers will be given by outstanding men in all branches of medicine, and there

will be more than 60 scientific exhibits. Varied evening programs of entertainment have been arranged, including a concert by the Denver Symphony Orchestra.

Dr. Hancock Named Pres.-Elect, Dr. Bailey AMA Delegate

J. Duffy Hancock, M. D., Louisville, was selected without opposition as president-elect of the Kentucky State Medical Association at the October 9 session by the House of Delegates.



Dr. Hancock

Dr. Hancock, who has long been active in the service of the Association, has represented Kentucky at the House of Delegates of the American Medical Association during three terms. In 1939 he was elected to the office to complete the unexpired term created by the resignation of E. L. Henderson, M. D., Louisville, and in 1940 was re-elected to serve another two years. After a tour of duty in the military service during World War II, he was again named to the A.M.A. in 1950.

Vice-presidents for the 1952-53 year chosen by the House were: W. O. Johnson, M. D., Louisville (Central Kentucky); Charles B. Johnson, M. D., Russell (Eastern Kentucky); G. Y. Graves, M. D., Bowling Green (Western Kentucky). Paul W. Simpson, M. D., Covington, was elected orator in medicine for the 1953 meeting, and Douglas E. Scott, M. D., Lexington, was chosen to present the oration in surgery.

W. Clark Bailey, M. D., Harlan, was chosen by the House as Kentucky's delegate to the A.M.A. for the years 1953, 54, and Thomas V. Gudex, M. D., Louisville, was named alternate. Other nominations to these contested offices were R. O. Joplin, M. D., Louisville, for delegate, and C. C. Howard, M. D., Glasgow, for alternate. Dr. Bailey served three two-year terms as Kentucky's delegate prior to his resignation in 1950 to become president-elect. Bruce Underwood, M. D., Louisville, secretary and general manager of the Association, is the other state delegate.

J. Farra Van Meter, M. D., Lexington, was nominated and elected without opposition as the councilor for the Tenth District. It was necessary to elect only one councilor at this

meeting. Action taken by the 1952 House set up machinery that will provide for the election of five councilors each year beginning in 1953.

Dr. Bailey Pleads for Liberty at Annual Dinner

The present unmatched peak of greatness in the medical profession has been achieved in a nation which has enjoyed individual liberty and protection of private property, Clark Bailey, M. D., Harlan, retiring president of the Kentucky State Medical Association, told a crowded ballroom of Kentucky physicians and guests at the annual dinner in the Brown Hotel, October 9.

If the "alien ideas" which are changing the character of the nation lead to adoption by Americans of socialistic doctrine, Dr. Bailey warned, medical progress will be shackled. Doctors are citizens first and doctors second; therefore, their first responsibility is to preserve liberty. "We find ourselves as a profession at the peak of leadership in the world, with other nations looking to us for guidance and continued leadership," he said.

R. Haynes Barr, M. D., Owensboro, who was inaugurated as president for the year 1952-53,



Ideal of personal liberty in America enabled 7 per cent of earth's population to out-produce all other peoples, Clark Bailey, M. D., tells dinner guests as he ends term as K.S.M.A.'s president. Clyde C. Sparks, M. D., left, re-elected Council Chairman, was toastmaster.

emphasized the role of public servant the doctor must play and charged new members with the responsibility to give both patient and family that extra measure of comfort and solace in time of stress that is natural to expect from his peculiarly close relationship to them.

Clyde C. Sparks, chairman of the Council of K.S.M.A., was toastmaster for the evening.

First-place winner in the annual golf tourney at Big Springs Country Club, with a net score of 70, was Eugene L. Marion, M. D., Glasgow, whom Dr. Sparks presented with a golf jacket. He was closely contested by Clifton G. Follis, M. D., Glasgow, Lanier Lukins, M. D., Louisville, and Wendell V. Lyon, M. D., Ashland, all of whom netted a 71 and all of whom must share second place and its prize of a single "shower stick."

Members of the K.S.M.A. along with an impressive number of their distinguished guests from many parts of the country were welcomed by Mayor Charles Farnsley of Louisville.

Radio, T-V Coverage of Annual Meeting Broadest Yet

Louisville radio and television stations extended the Association totals of one hour and twenty-five minutes television time and one hour and forty-five minutes of radio time on a public service basis during the 1952 annual meeting for the broadest coverage yet given the profession in this state by these media.

Visiting essayists, for the most part, appeared on the four television programs and made nine radio appearances. Subjects included in these broadcasts were civil defense, rural health, diabetes detection, and obstetrical anesthesia.

There were two half hour television programs on civil defense and one half hour radio panel on this subject, along with several appearances by visiting essayists on regularly scheduled features. One television station featured a fifteen-minute program on diabetes detection, and one of the radio stations a fifteen-minute program on rural health.

The officers and councilors expressed their appreciation for the splendid co-operation of these stations during the meeting. R. Haynes Barr, M. D., Owensboro, the recently installed president, made a personal visit to the officials of the co-operating stations the day after the annual meeting closed to express the Association's gratitude for the support received.

In addition to the guest essayists the following members participated in one or more programs: Clark Bailey, M. D., Harlan, Dr. Barr, G. Y. Graves, M. D., Bowling Green, Carlisle

Morse, M. D., Louisville, Emmet F. Horine, M. D., Brooks, Warren F. Sergeant, M. D., Lexington, Paul M. Crawford, M. D., Louisville, and C. Howe Eller, M. D., Louisville.

Dr. Sparks Re-elected Chairman as Council Reorganizes

Clyde C. Sparks, M. D., Ashland, was re-elected chairman, J. Farra Van Meter, M. D., Lexington, vice-chairman, and Bruce Underwood, M. D., Louisville, general manager at the reorganization meeting of the Council held during the last day of the annual meeting of the Kentucky State Medical Association, October 9.

Richard R. Slucher, M. D., Buechel, councilor from the Fifth District, and Branham B. Baughman, M. D., Frankfort, councilor from the Seventh District, were re-elected to serve on the Executive Committee of the Council. Dr. Sparks represents the Thirteenth District and Dr. Van Meter the Tenth District.

As a result of action by the House of Delegates on a recommendation of the committee to study the constitution and Kentucky laws, the size of the Executive Committee of the Council was increased by two members. Formerly, the Executive Committee was composed of five members: the president, the chairman of the Council, the secretary and general manager, and two members of the Council. The new action adds the president-elect and the vice-chairman of the Council. Under the by-laws the chairman of the Council serves as chairman of the Executive Committee.

It was pointed out that the Executive Committee, who had six meetings last year, greatly relieves the work of the Council and makes it possible for the Council to give greater consideration to the more important issues.

GP Wins Recognition in the Arts

GP, the journal of the American Academy of General Practice is among the magazines that have been adjudged outstanding for the year by the American Institute of Graphic Arts, New York.

The selection is made from the leading magazines of the country by six judges representing the better-known organizations in the entire publishing field. **GP** is less than three years old.

Hugh H. Hussey, M. D., Washington, D. C., is the medical editor of **GP**, and Mac F. Cahal is publisher.



John W. Scott, M. D., receives Association's Distinguished Service Medal from Secretary and General Manager Bruce Underwood, M. D., at annual public meeting.

Awards and Civil Defense Needs Highlight Public Meeting

Lack of immediate medical care, of proper facilities, supplies, and organization, rather than atomic radiation, were responsible for the great majority of fatalities and permanent injuries suffered at Hiroshima, Col. Gerald M. McDonnel, Washington, chief of the Armed Forces Special Weapons Project, told the Kentucky State Medical Association at its public meeting in the Columbia Auditorium, Louisville, October 7.

The vast backlog of supplies and the well organized populace needed to back the medical profession in its service to humanity during such an emergency simply were not available at Hiroshima, he said, and thousands of ordinary burn, fracture, hemorrhage, and shock cases became fatalities or permanent disfigurements because they went unaided in the prevailing chaos. Colonel McDonnel illustrated his talk with an instructive arrangement of documentary slide films of the stricken community.

Only two awards were made at the public meeting this year. John W. Scott, M. D., Lexington, received the Distinguished Service Medal, and Charles L. Sherman, M. D., Millwood, was recipient of the J. Watts Stovall Award, which was accepted by Francis M. Sherman, M. D., Owensboro, in his brother's absence. Both awards were voted at the opening meeting of the House of Delegates, October 6, and presented by Bruce Underwood, M. D., secretary and general manager of K.S.M.A.

Dr. Underwood announced that the E. M. Howard Award, usually made at this time, would be given in the future at the annual meeting of the Kentucky chapter of the American Academy of General Practice, which is held in April.



Native son Russ Hill warns K.S.M.A. against legislative cures for society's pain as featured speaker at President's luncheon.

Better Life Not Built by Legislation Hill Tells Luncheon Guests

Neither happiness nor health can be secured through legislation, T. Russ Hill, Detroit industrialist, told nearly 200 members and guests at the president's luncheon of the Kentucky State Medical Association, October 8, in the Brown Hotel, Louisville.

Clark Bailey, M. D., Harlan, who presided at the luncheon, introduced Mr. Hill and a number of the distinguished essayists who read papers at the annual meeting. Hill, a former Kentuckian, is president of the Martin-Parry Corporation, Detroit, Martin-Parry Limited, Toronto, and the Rexair Corporation, Detroit.

"Socialized medicine means a lower grade of medical service at more cost, as has been proven in England for over five years. Socialized anything else leads to the same results. No power or law can make an idle man industrious, a thriftless man provident, or a drunkard sober," Hill said. The answer to the gambling rackets, dishonest officials, dope peddling in schools lies within the individual, his independent search for the facts, and the moral courage to act on his convictions. As indicative of the state of the nation, which he likened to progressive disease, he cited a bulging bureaucracy with its two and one-half million Federal employees, a propaganda machine costing the taxpayers \$200 million annually, and "the 50-cent dollar."

Communism he described as a mistaken but flaming faith for which some are prepared to die as for a holy cause, and which must be met not by bomb or political campaign, but by a comparable faith of the individuals who want a free society.

New Advisory Committee Named to Blue Cross

A new committee, authorized by the Executive Committee of the Council and to be known as the Blue Cross Advisory Committee, was appointed late in September by R. Haynes Barr, M. D., Owensboro, then president-elect, at the request of Clark Bailey, M. D., Harlan, president.

The broad purpose of this committee, according to Dr. Bailey, is to formulate and promote a program designed to educate the medical profession in the procedures and abuses of the operation of voluntary non-profit plans.

Sam A. Overstreet, M. D., Louisville, of the Fifth Councilor District, was named chairman. Other members of the Committee by councilor district follow: First District, Orion L. Higdon, M. D., Paducah; Second, James E. Hix, M. D., Owensboro; Third, Harvey B. Stone, M. D., Hopkinsville; Fourth, John J. Sonne, M. D., Bardstown; Sixth, W. R. McCormack, M. D., Bowling Green; Seventh, Thomas Leonard, M. D., Frankfort; Eighth, C. Walker Air, M. D., Ludlow; Ninth, Harold Parker, M. D., Maysville; Tenth, Rankin Blount, M. D., Lexington; Eleventh, John C. Baker, M. D., Berea; Twelfth, George McClure, M. D., Danville; Thirteenth, Leslie Winans, M. D., Ashland; Fourteenth, Lloyd Hall, M. D., Salyersville; Fifteenth, Williard M. Buttermore, M. D., Harlan.



Charles L. Sherman, M. D., Millwood, winner of the J. Watts Stovall Award, could not be present to receive the honor in person.



Council Chairman Clyde C. Sparks, M. D., administers official oath to R. Haynes Barr, M. D., as new president of K.S.M.A. in ceremony at annual dinner, October 9. Seated on Dr. Barr's left are Clark Bailey, M. D., retiring president, and Mrs. Bailey.

House Acts on Important Issues in Two Four-Hour Sessions

Careful consideration of the more important issues characterized the actions of the 1952 meetings of the House of Delegates, with each session lasting more than four hours and with an attendance of 114 of the 176 delegates and officers eligible to attend.

The first session of the House was on Monday evening, October 7, at which officers' and committees' reports were introduced, many of them read. Tuesday afternoon the reference committees met for lengthy session. Attendance was very good, and many spoke for and against the various issues before the House. At its second session Wednesday evening, October 9, the House heard the reference committee reports and took action on them; they then elected officers for the new year.

The House voted to limit "awards, prizes, and medals authorized by the Kentucky State Medical Association to those donated by the Association" and stipulated "that all such awards bear a descriptive title or the name of some distinguished deceased Kentucky physician."

On one of the matters up for consideration the House of Delegates issued the following prepared statement: "The House of Delegates took no action on the application for a society of Negro physicians."

The House voted changes in the by-laws that set up procedures for the appointment of a nominating committee to select officers for the Association and authorized machinery for the "staggering" of councilors' terms of office so

that the terms of five councilors expire each year. A councilor may serve two three-year terms. The procedure voted by the House to stagger terms does not prohibit the eligibility of the councilor's serving his two full terms.

The House voted its official appreciation to Emmet F. Horine, M. D., Brooks, for his splendid services in editing and publishing the Centennial Volume without cost to the Association.

Other important House actions included the urging of county medical societies to form press-radio-physician-hospital codes, set up emergency call bureaus, and co-operate in plans to have courses for the instruction of office assistants and secretaries in the matter of dealing with the public, using the telephone, completing insurance forms, and other duties.

The House voted to ask the University of Louisville School of Medicine to establish a course for students during the senior year that might be called **Medical Manners and Public Service**, for the purpose of "familiarizing students with the importance and the methods of achieving proper public relations by the way the doctor conducts himself in the presence of the patient."

The December Journal will carry a detailed account of House of Delegates actions.

Over 31,000 veterans of Korean service applied for education and training under the Korean GI Bill in the first ten days after it became effective August 20, according to a recent release of the Veterans Administration.



K.S.M.A. staff assembles 175 delegate kits after mammoth typing and duplicating job of 71 committee and officer reports to distribute at House's opening session, October 6. Staff members, reading from the left, are Miss Violet Stilz, Mrs. Edna Coffey, Mrs. Joanne Fauth Watkins, Mrs. Daisy Hunt, and Miss Cecil Cowherd, and a temporary employee, Miss Betty Anne Mason.



Louisville's Mayor Charles T. Farnsley extend friendly greeting on behalf of city to state's physicians at annual dinner.

Ky. Chest Men Elect Officers, Hear Dr. Crimm

Lawrence O. Toomey, M. D., Bowling Green, was elected president of the Kentucky chapter of the American College of Chest Physicians at its noon meeting October 7, in the Brown Hotel, Louisville.

John S. Harter, M. D., and Lawrence A. Taugher, M. D., both of Louisville, were elected vice president and secretary-treasurer, respectively.

Medical surveys can be efficiently conducted on a self-supporting basis without the aid of state or Federal funds, Paul D. Crimm, M. D., guest speaker, told the group of 50 members and guests. Dr. Crimm, who read a paper at the annual meeting of the Kentucky State Medical Association, is a specialist in thoracic diseases and surgery and director and chest surgeon for 22 years of the Boehne Tuberculosis Hospital at Evansville.

Dr. Taugher said the Kentucky chapter has enough money in its treasury with which it hopes to provide an outstanding speaker next year for both the chapter itself and the K.S.M.A. meeting.

Dr. Leonard Appointed to Board

Thomas P. Leonard, M. D., Frankfort, has been named by Governor Lawrence W. Wetherby to complete the unexpired term of the late F. M. Travis, M. D., Frankfort, on the State Board of Health. Dr. Leonard was one of three nominated by the Council of the Kentucky State Medical Association for the post as provided for by the Kentucky Statutes, from which the Governor makes the appointment.

Counties Urged to Select Officers and Committees with Care

In a recent statement by President R. Haynes Barr, M. D., Owensboro, discussing the importance of year-end activities of the local county medical societies and their relationship to the program of organized medicine, three points were emphasized:

1. Careful and wise selection of officers to head the county medical society for the coming year.

2. Adequate and prompt consideration to the appointment of sufficient committee personnel to carry on the work of the county society and co-operate with the programs of the State Medical Association.

3. Local member co-operation with the secretary of the county medical society. (Stating the secretary had to make a living just as other members have to do, Dr. Barr urged the membership to pay their county, state and A.M.A. dues promptly and not obligate the secretary to waste his time by becoming a "bill collector.")

The secretary was urged to send the headquarters offices of K.S.M.A. the following basic information at the conclusion of the annual meeting of the county society: (1) Names of county society officers and delegates to annual state meeting; and (2) personnel list of legislative, public relations, rural health, and diabetes committees, and committee on emergency medical service.

Materials for the use by county medical society secretaries in making annual reports on the election of officers, appointment of delegates and committees, and the collection of annual dues will go forward to them from the headquarters office the latter part of November.

"One of the chief functions of the State Medical Association is to co-operate with and make more effective the efforts of the local medical society," Dr. Barr said. "The officers and headquarters staff hold themselves in readiness to furnish members with both efficient and prompt service. Such efforts will be made much easier if we can know the personnel of each county official family as early as possible."

The Defense Department is calling up 460 physicians for December, compared with 341 in November; 285 of the new quota will go to the Army, the remainder to the Air Force. Priorities 1 and 2 will meet the call; Priority 3's are not expected to be reached until about March, 1953.

AMA Approves Move to Organize Public Health M. D.'s

The following statement appeared in the October 8 Secretary's Letter of the American Medical Association, signed by Ernest B. Howard, M. D., assistant secretary.

"A movement has been underway for quite some time to form an American Association of Public Health Physicians.

"The movement, endorsed and approved by the A.M.A. Board of Trustees several months ago, was promoted by the following committee: Drs. Bruce Underwood, Louisville, chairman; Wilson T. Sowder, Jacksonville, Fla.; Grady F. Mathews, Oklahoma City; R. C. Williams, Atlanta; S. J. Phillips, New Orleans; and Frank E. Wilson, Washington.

"The plan, which already has the support of many state and local health physicians on an informal individual basis, will be offered for consideration of the executive committee of the American Public Health Association when it meets in Cleveland late this month. The committee hopes also that it will have the endorsement and active sponsorship of the Association of State and Territorial Health Officers.

"A statement, issued recently by the committee, follows in part:

'The general purpose is to provide an Association of American Public Health Physicians to which the Public Health Physicians in Local and State and Territorial Health Departments may belong. We feel there is a need for an American Association of Public Health Physicians. At the present time, there is no single agency or group which can officially speak for the Public Health Physicians of this country.

'The American Medical Association primarily represents the practitioners of medicine; the American Dental Association represents the dentists; the American Hospital Association represents the hospitals; the American Psychiatric Association represents the psychiatrists, and there are many other associations which represent various health and medical professions; but, there is none that adequately represents the Public Health Physicians.

'The American Public Health Association has a section for health officers, but the association includes a majority of non-medical persons, and, for this and other reasons, the association cannot, by its very nature, speak adequately for the Doctors of Medicine engaged in preventive medicine and public health.

'The Association of State and Territorial Health Officers does not include district or local Public Health Physicians. Neither can the Conference of State and Provincial Health Au-



Arthur R. Colwell, M. D., Chicago medical educator, administrator, and writer addresses a morning session of K.S.M.A. meeting on treatment of diabetes.

thorities of North America, for the same reasons, represent all physicians engaged in preventive medicine and public health.

'All Public Health Physicians in this country should belong to and actively participate in affairs of the American Medical Association. Likewise they should belong to and actively participate in the affairs of the American Public Health Association. But, in addition, the Public Health Physicians of this country need an association limited to Doctors of Medicine in the field of preventive medicine and public health that can adequately represent their views nationally. The purpose of the association will be to foster and maintain leadership consistent with the ethical standards and fraternal desires of these medical administrators.'"

Annual Meeting Attracts 1,585

A total of 1,585 members and guests of the Association registered for the 1952 annual meeting, October 7, 8, and 9, at the Columbia Auditorium, Louisville

Officials of the Association expressed themselves as being well pleased with the excellent attendance and interest shown in the scientific sessions that featured guest essayists.

Classified registration was as follows:

Members	693
Guest physicians	67
Guests	80
Medical students	252
Registered nurses	16
Interns, Residents	73
Technicians, Office assistants	49
Exhibitors	180
Auxiliary	175

Total 1,585

Questions on M. D. Procurement Answered by Committee

The Advisory Committee to Selective Service receives many questions relative to the operation of Public Law 779 (The Doctor Draft Act) and the procurement of medical personnel for the Armed Forces in general.

Typical of these questions were some inquiries made by the president of one of the larger county medical societies. Below are listed the questions and excerpts from a letter written by A. Clayton McCarty, M. D., Louisville, chairman of the committee, replying to them.

After stating some of his members were very concerned, the county society president asked: (1) What is the procedure in Kentucky? (2) Who has the final say? (3) How are the local committees set up? (4) What is the responsibility of the councilor?

The committee's reply follows:

"We can easily understand that many of your men are concerned and perhaps confused over the operation of Public Law 779. We are frank to admit that we are unable to get satisfactory answers to a lot of questions ourselves.

"There are still some Priorities I and II men that have not been called. While in conversation yesterday with Paul C. Barton, M. D., Executive Secretary of the National Advisory Committee in Washington, we were told that Selective Service expects to clean up the majority of the available Priority I and II doctors by the first of the year or shortly thereafter. When these men have been absorbed, they will of course go into Priority III. Under the law men in Priorities I and III are called according to age, the youngest being taken first. In Priorities II and IV, the men with the least amount of service will be called first.

"Your first question is what is the procedure in Kentucky. Selective Service is now processing men in Priority III in the younger ages. That means that they are first determining their physical and professional qualifications. When this is done, then the Kentucky Advisory Committee to Selective Service is asked to pass on their essentiality to the community if they are otherwise qualified.

"When our committee is asked to pass on the availability of a given doctor, the state committeeman who works with the councilor district in which the doctor is located, gets a request from our office. He in turn asks the councilor of the district in which the doctor in question is located for an opinion. The councilor in turn asks the local committee to pass on the eligibility of said doctor.

"When the local committee advises the councilor, who is the district chairman, the councilor then advises the state committeeman and the state committeeman sends the recommendations to me. If everyone along the line is in agreement as to the essentiality of subject doctor, then Selective Service is so informed. If there is a disagreement, then no action is taken on the subject doctor's situation until the committee can have a full meeting. The state committee and the councilors, of course, lean heavily on the recommendations of the local county committee.

"Your next question is who has the final say. The advice of this committee is only advisory and the Selective Service people are not bound by law nor are the reserve components of the armed forces bound by law to accept our recommendation as final. However, the recommendations of this committee have been accepted in all instances except a few cases with the Naval Reserve. Actually, the local draft board has the final say in case of the men under selective service.

"Your next question is how are local committees set up. As pointed out some months ago in the Journal of the State Medical Association, the local county society selects the local committee in any way it sees fit.

"Your next question is what is the responsibility of the councilor. We believe we have covered that in the description of the procedures.

"We would like to make it eminently clear that the Kentucky Advisory Committee has no voice whatever in determining who will be considered for active duty either in the reserve components or by Selective Service. Our only function is to give a yes or no answer on each individual request that is made of us. We want to emphasize once more our committee cannot and does not determine who will be considered for active duty."

New KSMA Members Welcomed

The Association is pleased to welcome the following new members:

Clark—Charles F. Martin, Winchester.

Fayette—James Holloway, Betty S. Wheeler, Andrew Moore, all of Lexington.

Jefferson—David W. Griffin, Condict Moore, Burton M. Heine (Intern), William E. Hopkins, Richard B. Jarvis, Elmo K. Hughes, Robert A. Switzer, George S. Allen, Helen C. Hubbard, L. Douglas Atherton, all of Louisville.

Owen—Paul Harrison, Owenton.



Bat Cave's (N. C.) famed "country doctor," George Bond, M. D., discusses rural practice before the K.S.M.A. annual assembly.

Committee Appointments for Year Listed; Activity Urged

Both presidential and Council appointed committees to serve during the 1952-53 year were announced following the annual meeting.

President R. Haynes Barr, M. D., Owensboro, and Chairman of the Council Clyde C. Sparks, M. D., Ashland, explained in making the announcement that every effort was being made to give the new committees every opportunity to have a full year to function.

Both officials stressed the importance of committee activity in the program of state organization and urged the chairmen of these committees to summon their committees at an early date and make plans for the new year.

The 1952-53 committee appointments follow:

STANDING COMMITTEES

Committee on Arrangements

J. Duffy Hancock, Louisville, Chairman
Elmer S. Maxwell, Lexington
Robert L. Reeves, Paducah
Norman Adair, Covington
Charles B. Stacy, Pineville

Committee on Scientific Assembly

R. Haynes Barr, Owensboro, Chairman
J. Duffy Hancock, Louisville
T. O. Meredith, Harrodsburg, 1 year (term expires 1953)
Carl W. Kumpe, Covington, 2 years (term expires 1954)
Charles C. Rutledge, Pikeville, 2 years (term expires 1954)
Bruce Underwood, Louisville, Secretary

Public Relations Committee

David Cox, Louisville, Chairman, 1 year (term expires 1953)
Glenn Bryant, Louisville, 3 years (term expires 1955)
William Pennington, Lexington, 1 year (term expires 1953)
Edward Wilson, Jr., Pineville, 2 years (term expires 1954)
C. Walker Air, Ludlow, 3 years (term expires 1955)

Committee on Medical Service

G. L. Simpson, Greenville, Chairman, 2 years (term expires 1954)
Alfred Miller, Louisville, 2 years (term expires 1954)
Walter Cawood, Harlan, 1 year (term expires 1953)
Cy Waldrop, Williamstown, 3 years (term expires 1955)
Kenneth L. Barnes, Princeton, 1 year (term expires 1953)

Committee to Study the Constitution and By-Laws

William L. Woolfolk, Owensboro, Chairman
Cooley L. Combs, Hazard
Wyatt Norvell, New Castle
Ernest C. Strode, Lexington
R. Ward Bushart, Fulton

Medico-Legal Committee

J. B. Lukins, Louisville, Chairman
Woodford B. Troutman, Louisville, Ex-Officio
Bruce Underwood, Louisville, Ex-Officio
Clark Bailey, Harlan, Consultant
Lanier Lukins, Louisville, Consultant

SPECIAL COMMITTEES

Kentucky Committee for Contributions to American Medical Education Foundation

J. Duffy Hancock, Louisville, Chairman
M. O. Crowder, Owensboro
J. Gant Gaither, Hopkinsville
M. J. Henry, Louisville
Sam A. Overstreet, Louisville
Winfrey P. Blackburn, Frankfort
Harold Parker, Maysville
Edward H. Ray, Lexington
Wendell V. Lyon, Ashland
James A. Ryan, Covington
Keith Crume, Bardstown

Diabetes Committee

Carlisle Morse, Louisville, Chairman
George N. Burger, Covington
Frank H. Moore, Bowling Green
Herald K. Bailey, Ashland
Franklin B. Moosnick, Lexington
Luther Bach, Lexington
William P. Hall, Paducah

William R. Parks, Harlan
Guinn S. Cost, Hopkinsville
H. E. Titsworth, Clinton
Marcus A. Coyle, Springfield
L. A. Wahle, Shelbyville

Advisory Committee to the Editor

Guy Aud, Louisville, Chairman
Richard J. Rust, Newport
James E. Hix, Owensboro

Education Campaign Committee

W. Vinson Pierce, Covington, Chairman
George F. Brockman, Greenville
George W. Pedigo, Louisville
Richard G. Elliott, Jr., Lexington
Wendell V. Lyon, Ashland
Charles B. Stacy, Pineville
B. N. Pittinger, Paris

Committee on Emergency Medical Service

Guthrie Y. Graves, Bowling Green, Chairman
Thomas Van Zandt, Gudex, Louisville
Orion L. Higdon, Paducah
Leland E. Payton, Lynch
W. Mountjoy Savage, Maysville
John S. Sprague, Lexington

Advisory Subcommittee on Speakers Bureau

J. Gant Gaither, Hopkinsville, Chairman
David Cox, Louisville
George McClure, Danville
Charles B. Billington, Paducah

Subcommittee on Training

Charles Wood, Louisville, Chairman
Rankin C. Blount, Lexington
Willet H. Rush, Frankfort
M. O. Crowder, Owensboro
Ralph Gettlefinger, Louisville

Subcommittee on Supplies

Charles B. Stacy, Pineville, Chairman
Gerald Edds, Calhoun
William S. Morgan, Paris
Robert E. Pennington, London
W. S. Snyder, Frankfort

Subcommittee on Blood Banks

W. Mountjoy Savage, Maysville, Co-Chairman
Marion F. Beard, Louisville, Co-Chairman
Matthew C. Darnell, Lexington
Stuart P. Hemphill, Danville
James M. Huey, Walton
Edgar S. Weaver, Carrollton

Subcommittee on Hospitals

Leland E. Peyton, Lynch, Chairman
Norman Adair, Covington
M. O. Crowder, Owensboro
Sam Flowers, Middlesboro
Burr Atkinson, Lebanon
George F. Brockman, Greenville

James E. Moore, Ashland

Subcommittee on Publicity

Harper Richey, Louisville, Chairman
C. Walker Air, Ludlow
Coleman Johnston, Lexington
Charles E. Brenn, Owensboro

Subcommittee on Radio

J. Duffy Hancock, Louisville, Chairman
William O. Preston, Lexington
William I. Huesing, Newport

Subcommittee on Mobile Units

Thomas V. Gudex, Louisville, Chairman
John S. Sprague, Lexington
Leon Higdon, Paducah
Henry Harris, Bowling Green
Paul A. Bryant, Ashland
Wyatt Norvell, New Castle

Committee on Hospitals

Joseph C. Bell, Louisville, Chairman
Thomas V. Gudex, Louisville
W. O. Johnson, Louisville
Francis Massie, Lexington
Richard J. Rust, Newport
Charles B. Wathen, Owensboro
Leon Higdon, Paducah
Dana Snyder, Hazard

Kentucky State Advisory Committee to Selective Service

A. Clayton McCarty, Louisville, Chairman
J. Duffy Hancock, Louisville, Vice-Chairman
Charles B. Billington, Paducah
Glenn U. Dorroh, Lexington
R. Arnold Griswold, Louisville
L. O. Toomey, Bowling Green
Marcus Randall, D. D. S., Louisville, Sub-Chairman
Frank W. Jordan, D. D. S., Louisville
O. B. Coomer, D. D. S., Louisville
F. E. Hull, D. V. M., Lexington, Sub-Chairman
Lula B. McClain, R. N., Louisville, Subchairman

K. S. M.A. Dental Committee

Thomas J. Crume, Owensboro, Chairman
Charles Bryant, Louisville
W. S. Snyder, Frankfort
J. E. Moore, Ashland
John S. Newman, Henderson
Rex Hayes, Glasgow

K.S.M.A. Pharmacy Committee

George McClure, Danville, Chairman
Travis Pugh, Bowling Green
George Archer, Prestonsburg
Matthew C. Darnell, Lexington
Roy Wilson, Campbellsville
James S. Stevenson, Brooksville

Legislative Committee

B. B. Baughman, Frankfort, Chairman

Thomas V. Gudex, Louisville, Co-Chairman
 Rufus C. Alley, Lexington
 Guy Aud, Louisville
 Clark Bailey, Harlan
 C. C. Howard, Glasgow
 Charles B. Stacy, Pineville
 Charles B. Wathen, Owensboro
 Billy K. Keller, Louisville
 E. W. Jackson, Paducah
 Norman Adair, Covington
 J. Gant Gaither, Hopkinsville

Board of Directors of McDowell Memorial Foundation

Charles A. Vance, Lexington, Chairman, 2 years (term expires 1954)
 Russell Starr, Glasgow, 2 years (term expires 1954)
 E. M. Howard, Harlan, 2 years (term expires 1954)
 George McClure, Danville, 1 year (term expires 1953)
 Laman A. Gray, Louisville, 1 year (term expires 1953)
 Emil Novak, Baltimore, Maryland, 1 year (term expires 1953)
 Thomas O. Meredith, Harrodsburg, 3 years (term expires 1955)
 Irvin Abell, Louisville, 3 years (term expires 1955)
 Orion L. Higdon, Paducah, 3 years (term expires 1955)

Committee on Medical Education

Robert Lich, Jr., Louisville, Chairman
 D. G. Miller, Jr., Morgantown
 Lawrence T. Minish, Louisville
 J. R. Gott, Louisville
 Herbert L. Clay, Jr., Louisville
 O. T. Davis, Owensboro
 Frederick A. Scott, Madisonville

Special Committee on Medical Education

Sam A. Overstreet, Louisville, Chairman
 J. Murray Kinsman, Louisville
 Bruce Underwood, Louisville

Medical School Advisory Committee (appointed in July of each year)

Karl Winter, Louisville, Chairman, 3 years (term expires 1955)
 C. C. Howard, Glasgow, 3 years (term expires 1955)
 John S. Llewellyn, Louisville, (term expires 1953)
 Charles A. Vance, Lexington, 3 years (term expires 1955)
 W. Vinson Pierce, Covington, 1 year (term expires 1953)
 Paul B. Hall, Paintsville, 1 year (term expires 1953)
 Clark Bailey, Harlan, 1 year (term expires 1953)

George McClure, Danville, 2 years (term expires 1954)
 G. L. Simpson, Greenville, 2 years (term expires 1954)
 J. Vernon Pace, Paducah, 2 years (term expires 1954)

Committee on Nurse Training

James E. Hix, Owensboro, Chairman
 Hugh L. Houston, Murray
 Chris Jackson, Danville
 Winfrey P. Blackburn, Frankfort
 William McCormack, Bowling Green
 John W. Armstrong, Berea
 Everett Blair, Morehead

Professional Relations Committee

Guy Aud, Louisville, Chairman
 Charles A. Vance, Lexington
 Hugh L. Houston, Murray
 Sam A. Overstreet, Louisville
 Clark Bailey, Harlan

Committee for World Medical Association

Walter Cawood, Harlan, Chairman
 Ralph Gettlefinger, Louisville
 Ralph Gullett, West Liberty
 Russell Scott, Dixon

ADVISORY COMMITTEES ON MEDICAL CARE

Advisory Committee on Blood Banks

Marion F. Beard, Louisville, Chairman
 Burr Atkinson, Campbellsville
 Winfrey P. Blackburn, Frankfort
 George McClure, Danville
 Hubert C. Jones, Berea
 Dana Snyder, Hazard
 A. J. Miller, Louisville
 H. C. Burkhart, Harlan
 Samuel Adams, London
 W. Thomas McElhinney, Covington
 John B. Floyd, Jr., Lexington
 Luther Bach, Lexington
 David Y. Keith, Paducah
 W. Mountjoy Savage, Maysville

Advisory Committee on Cancer

*Richard J. Rust, Newport, Chairman
 *Chris Jackson, Danville
 Karl Winter, Louisville
 Ernest C. Strode, Lexington
 Jack C. Blackstone, Owensboro
 B. B. Holt, Ashland
 George A. Sehlinger, Louisville
 Richard R. Crutcher, Lexington

*Committee members who will serve on Cancer Co-ordinating Council.

Advisory Committee on Crippled Children

Charles Wood, Louisville, Chairman
 Ruel T. Routt, Sonora
 J. E. Bickel, Owensboro
 Franklin B. Moosnick, Lexington

Leslie H. Layman, Louisville
K. Armand Fischer, Louisville

Advisory Committee on General Practice

Travis Pugh, Bowling Green, Chairman
J. Auldin Bishop, Jeffersontown
M. R. Cronen, Louisville
R. E. Davis, Central City
Garnett Sweeney, Liberty

Advisory Committee on Industrial Medicine and Surgery

Gradie R. Rowntree, Louisville, Chairman
John T. Bate, Louisville
E. Aulden Terry, Louisville
Burton A. Washburn, Paducah
W. Vernon Lee, Covington

Advisory Committee on Mental Hygiene and Mental Institutions

Spafford Ackerly, Louisville, Chairman
Billy K. Keller, Louisville
John P. Bell, Louisville
Robert C. Smith, Newport
Frank L. Duncan, Monticello
Charles B. Billington, Paducah
Ralph Lynn, Elkton

Advisory Committee on Obstetrics

W. H. Parker, Owensboro, Chairman
Robert Monroe, Louisville
W. P. Eubank, Louisville
William I. Huesing, Newport
Charles N. Hall, Versailles

Advisory Committee on Pediatrics

W. W. Nicholson, Louisville, Chairman
F. Hays Threlkel, Owensboro
Alex J. Alexander, Lexington
Robert N. McLeod, Somerset
Guy C. Cunningham, Paducah
William J. Temple, Covington

Advisory Committee on Physical Therapy

J. E. Bickel, Owensboro, Chairman
R. T. Hudson, Louisville
Harry Moody, Cynthiana
Melvin Dean, Lexington
Owen Pigman, Whitesburg
Robert J. Hoffmann, S. Fort Mitchell

Advisory Committee on Public Health

C. C. Howard, Glasgow, Chairman
J. C. Woodall, Trenton
J. M. Dishman, Greensburg
C. M. Bernhardt, Louisville
Cooley Combs, Hazard
C. B. Johnson, Greenup
J. B. Floyd, Jr., Lexington

Advisory Committee on Rural Health

Walter L. O'Nan, Henderson, Chairman
D. Y. Keith, Paducah
W. Lee Tyler, Jr., Owensboro
Donald W. Anderson, Madisonville
Sam A. Rector, Munfordsville

J. Auldin Bishop, Jeffersontown
D. G. Miller, Jr., Morgantown
George H. Riley, Erlanger
James M. Stevenson, Brooksville
Ben F. Roach, Midway
Donald L. Graves, Frenchburg
Gamett J. Sweeney, Liberty
Grady Stewart, Olive Hill
Carl Pigman, Whitesburg
George M. Asher, Pineville
B. Ralph Wilson, Sharpsburg
Philip Carter, Louisa
Michael M. Hall, Campbellsville
Wyatt Norvell, New Castle

Advisory Committee on School Health

Daryl P. Harvey, Glasgow, Chairman
H. B. Mack, Pewee Valley
William J. Temple, Covington
Carl Grant, Winchester
Walter L. O'Nan, Henderson
D. G. Miller, Jr., Morgantown
Carl Pigman, Whitesburg
W. E. Hoy, Ashland

Advisory Committee on Tuberculosis

*George W. Pedigo, Louisville, Chairman
*Hugh L. Houston, Murray
E. J. Murray, Lexington
Franklin Hall, Paris
B. F. Shields, Shelbyville
Joseph H. Humpert, Covington

*Committee members who will serve on Tuberculosis Co-ordinating Council.

OTHER ADVISORY COMMITTEES

Advisory Committee on Blue Cross

Sam A. Overstreet, Louisville, Chairman
Orion L. Higdon, Paducah
James E. Hix, Owensboro
Harvey B. Stone, Hopkinsville
John J. Sonne, Bardstown
W. R. McCormack, Bowling Green
Thomas Leonard, Frankfort
C. Walker Air, Ludlow
Harold Parker, Maysville
Rankin C. Blount, Lexington
John C. Baker, Berea
George McClure, Danville
Leslie Winans, Ashland
Lloyd Hall, Salyersville
Willard M. Buttermore, Harlan

Advisory Committee to the State American Legion

R. R. Slucher, Buechel, Chairman
G. L. Simpson, Greenville
Travis Pugh, Bowling Green
B. H. Warren, Owensboro
J. Auldin Bishop, Jeffersontown

Advisory Committee on United Mine Workers Health and Welfare Fund

Carl H. Fortune, Lexington, Chairman
C. D. Snyder, Hazard

Adam G. Osborne, Pikeville
Charles R. Yancey, Hopkinsville
George F. Brockman, Greenville
Clark Bailey, Harlan
Thomas V. Gudex, Louisville
Alfred O. Miller, Louisville

Advisory Committee to Woman's Auxiliary

Karl Winter, Louisville, Chairman
J. Farra Van Meter, Lexington
R. Ward Bushart, Fulton

OTHER CONVENTION COMMITTEES

Committee on Scientific Exhibits

Everett L. Pirkey, Louisville, Chairman
D. Woolfolk Barrow, Lexington
Harold Gordon, Louisville
Jesshill Love, Louisville
William P. Humphrey, Sturgis
H. Todd Smiser, Cynthiana

Committee on Technical Exhibits

Carlisle R. Petty, Louisville, Chairman
Edgar S. Weaver, Carrollton
Clyde H. Foshee, Louisville
Arthur T. Hurst, Louisville
Jesse Funk, Bowling Green

Centennial Committee

Sam A. Oversereet, Louisville, Chairman
W. Clark Bailey, Harlan
R. Haynes Barr, Owensboro
J. Duffy Hancock, Louisville
Emmet F. Horine, Brooks
William R. McCormack, Bowling Green
Richard R. Slucher, Buechel

Conference of Presidents and Other Officers of State Medical Associations

R. Haynes Barr, Owensboro

financing of health service, personnel, education, and research; and excerpts from regional public hearings. The Commission's staff will write the report, which will be edited by H. B. van Wesep, head of the Office of Publications of the Rockefeller Foundation, New York, as it is produced by the Commission.

Since re-examinations began the first of the year, 33,000 former 4F's out of 114,000 have qualified under lowered mental standards, and 17,000 of these are already in uniform. There are 186,000 awaiting re-examination, which occurs at the rate of about 25,000 a month.

The Pan-American Medical Association will sponsor a 25th Anniversary Cruise-Congress for physicians and their families aboard the SS Nieuw Amsterdam, January 7 to 19, according to Joseph J. Eller, M. D., New York, chairman, Section of Dermatology, P.A.M.A., and member of the committee for the Eighth Medical Cruise Congress. Stops will be made in Haiti, Colombia, Canal Zone, and Cuba. Rates for the 12-day vacation cruise are \$300 up.

Papers covering all branches of medicine and surgery will be given at the morning scientific sessions, and physicians are invited to submit 50-word abstracts to the program committee for consideration. Executive offices are at 745 Fifth Avenue, New York 22, N. Y.

A new measure, similar to the S. 3314 providing a Federal Board of Hospitalization, is now before the Senate Government Operations Committee and is expected to be amended to include one of a number of changes suggested by the American Medical Association as well as other revisions, according to a committee staff spokesman. The proposed membership was too heavily weighted in favor of Government membership, A.M.A. pointed out, and should be decreased to at least a 50 per cent representation.

The staff is also studying recommendations by other organizations.

The 15th Annual Duke Medical Symposium will be held on the West Campus of Duke University, Durham, North Carolina, December 9 and 10, and will be built around recent significant advances in the treatment of common disorders. Approximately ten authorities of national prominence will discuss the subjects, and facilities will be provided for audience participation in the form of comments and questions.

Pertinent Paragraphs

The big job for the President's Commission on the nation's health needs has begun: drafting and compiling its final report and recommendations for completion between December 1 and 15.

The Commission began its work after hearing two days of testimony by 21 professional and lay representatives on the controversial problem of financing medical care.

The report will start with a 100-page summary of "the state of the nation's health." Other documents to be published are 500 pages on the nation's health status, needs and resources; a statistical appendix on health status with tables and charts; a statistical appendix on the

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CONSTITUTION AND BY-LAWS OF THE KENTUCKY STATE MEDICAL ASSOCIATION

CONSTITUTION

- Article I. Name of the Association
- Article II. Purpose of the Association
- Article III. Component Societies
- Article IV. Composition of the Association
- Article V. House of Delegates
- Article VI. Sections and District Societies
- Article VII. Sessions and Meetings
- Article VIII. Officers
- Article IX. Funds and Expenses
- Article X. Referendum
- Article XI. The Seal
- Article XII. Amendments

BY-LAWS

- Chapter I. Membership
- Chapter II. Annual and Special Sessions of the Association
- Chapter III. General Meeting
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CONSTITUTION

Article I. Name of the Association

The name and title of this organization shall be the Kentucky State Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science, to the elevation of the standard of medical education and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians and to the guarding and fostering of their material interest and to the enlightenment and direction of public opinion in regard to the great problem of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public

in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those county medical societies which hold charters from this Association.

Article IV. Composition of the Association

The Association shall consist of the members of the component societies as defined in the By-Laws.

Article V. House of Delegates

Section 1. The House of Delegates shall be the legislative and business body of the Association.

Section 2. Delegates shall be members of and elected by component societies in accordance with the By-Laws. Officers of the Association and Delegates to the American Medical Association and the five immediate Past-Presidents shall be ex-officio members of the House of Delegates and entitled to vote.

Section 3. The Speaker or Vice-Speaker shall preside during the meetings of the House of Delegates. The Presiding Officer shall not be entitled to a vote except in the event of a tie vote.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VI. Sections and District Societies

The House of Delegates may provide for a division of the scientific work of the Association into appropriate Sections and for the organization of such Councilor District Societies as will promote the best interest of the profession, such societies to be composed exclusively of members of component county societies.

Article VII. Sessions and Meetings

The Association shall hold an annual session and such special sessions as may be desirable in accordance with the By-Laws of the Association.

Article VIII. Officers

Section 1. The Officers of this Association shall be a President, a President-Elect, three Vice-Presidents, a Secretary, a Treasurer, a Speaker and Vice-Speaker of the House of Delegates, and a Councilor from each Councilor District that may be established and such other Officers as provided for in the By-Laws.

Section 2. The Officers of the Association shall serve for the term of office and subject to provisions as specified in the By-Laws.

Section 3. All Officers shall serve until their successors have been elected and installed.

Section 4. The Officers of the Association shall be elected at the last session of the House of Delegates at the annual session of the Association and shall take office on that day unless otherwise specified.

Article IX. Funds and Expenses

Funds for meeting the expenses of the Association shall be arranged for by the House of Delegates by an equal per capita assessment upon each county society to be fixed by the House of Delegates by voluntary contribution and from the profits of its publication. Funds may be appropriated by the House of Delegates to defray the expenses of the Annual Session, for publication and for such other purposes as will promote the welfare of the Association and profession.

Article X. Referendum

The General Meeting of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may, by a similar vote of its own members or after a like vote of the General Meeting, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question and be binding upon the House of Delegates.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Session, provided that such amendment shall have been presented in open meeting at the previous Annual Session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

BY-LAWS

Chapter I. Membership

Section 1. A member of this Association must be a member of one of the component societies and when certified to the Secretary of the Association as a member of a component society,

properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary of the Association the name of the member shall be included in the official roster of the Association and the member shall be entitled to all the privileges of his class membership.

Section 2. Active Members. Active members shall comprise the active members of the component medical societies. To be eligible for active membership in any component county society the applicant must be:

A. A doctor of medicine who is licensed to practice medicine in the State of Kentucky and who is of good moral and professional standing.

B. A medical officer of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other governmental service while on duty in the State.

C. Any doctor of medicine engaged in scientific or professional pursuits whose principles and ethics are consonant with those of the State Association.

Section 3. Associate Members. Associate members shall consist of associate members of the component medical societies who are not eligible for active membership and who are qualified under one or more of the following groups:

A. An intern, resident or teaching fellow who is a Doctor of Medicine but who is not licensed to practice medicine in the state.

B. A person who is not a Doctor of Medicine but who is engaged in scientific, professional or other pursuits, whose principles and ethics are consonant with those of the Association.

C. A Doctor of Medicine residing and practicing outside the area covered by the component society and who is an active member in good standing in his own component society.

Associate members shall not have the right to vote nor to hold office. The Council shall, from time to time, determine the amount of dues to be charged. Associate members shall receive the Journal and the publications of the Association.

Section 4. Emeritus Members. Component societies may elect as a Member Emeritus any Doctor of Medicine who has retired from active practice and who has previously maintained active membership in good standing in his society. Emeritus members shall not have the right to vote nor to hold office and shall not pay dues. They shall receive the Journal and other publications of the Association.

Section 5. Student Members. Any student in an accredited medical school in Kentucky

or any resident of Kentucky who is a student in an accredited medical school in the United States shall be eligible for student membership. Student members shall not have the right to vote nor hold office. They may apply directly to the State Association for membership and be assigned to the county society of their choice. The Council shall determine, from time to time, the amount of dues to be charged. Student members shall receive the Journal of the Association. The membership year for student members shall run from September 1 to August 31 of each year.

Section 6. Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent State Medical Association and who has participated in the program of the Scientific Session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privilege on the floor in all scientific sessions.

Section 7. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any annual session upon invitation of the Association or its Council and shall be accorded the privilege of participating in all of the scientific work of that session.

Section 8. The name of a physician upon the properly certified roster of members or list of delegates, of a chartered county society which has paid its annual assessment, shall be prima facie evidence of his right to register at the Annual Session in the respective bodies of this Association.

Section 9. No persons who are under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its rolls of membership shall be entitled to any of the rights or benefits of this Association, nor its proceedings until such time as he has been relieved of such liability.

Section 10. Each member in attendance at the Annual Session shall enter his name on the registration book indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that session. No member or delegate shall take part in any of the proceedings of an annual session until he has complied with the provision of this section.

Chapter II. Annual and Special Sessions of The Association

The Association shall hold an annual session

and such special sessions at such time and place as may be determined by the House of Delegates.

Chapter III. General Meeting

The General Meeting shall include all registered active members, associate members and guests. Associate members and guests shall not have the right to vote on pending questions, but shall have equal rights with active members to participate in the proceedings and discussions. Each General Meeting shall be presided over by the President or in his absence or disability or upon his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the annual orations and the entire time of the sessions as far as may be, shall be devoted to papers and discussions relating to scientific medicine.

Chapter IV. House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Session of the Association and shall so fix its hours of meeting as not to conflict with the first General Meeting of the Association, or with the meeting held for the address of the President and the annual orations so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interest of the association and profession require, it may meet in advance or remain in session after the final adjournment of the General Meeting. The House of Delegates may be called into special session by the President with the approval of the Council and a special session of the House of Delegates shall be called by the President on a written request of the delegates representing fifty or more component county societies. When such special session is called, the Secretary shall mail a notice of the time and place and purpose of such meeting to the last known address of each member of the House of Delegates at least ten days before such special session.

Section 2. In the event there is no duly authorized delegate in attendance at the regular meeting of the House of Delegates the President shall consult any duly elected officer of the component society who is in attendance and with the approval of the Credentials Committee may appoint any active member of the component society in attendance at the meeting as the delegate. In the event there is no duly elected officer of the component society in attendance, the President may make the said appointment with the approval of the Credentials Committee. All appointments made

shall also be with the approval of the House of Delegates.

Section 3. A majority of the registered delegates shall constitute a quorum and all of the meetings of the House of Delegates shall be open to members of the Association. The House of Delegates shall have the right to go into executive session whenever such action is indicated in the judgment of the House of Delegates, except that active members of the Association shall have the right to attend all executive sessions.

Section 4. From among the members of the House of Delegates the Speaker of the House of Delegates shall appoint a Committee on Credentials, Rules and Order of Business, Report of Officers and the Council, Report of Standing Committees, Report of Special Committees, Report of Advisory Committees, Resolutions, Miscellaneous Business, Revision of By-Laws and Constitution, and such other committees as he may deem necessary, as well as Tellers and Sergeant-At-Arms. All appointments by the Speaker of the House of Delegates are subject to approval by the House of Delegates.

Section 5. Each Resolution introduced into the House of Delegates shall be in writing and presented to the Secretary. Immediately after the Delegate has introduced the Resolution, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 6. No new business shall be introduced in the last meeting of the House of Delegates without unanimous consent of the Delegates except when presented by the Council. All new business so presented shall require three-fourths affirmative vote for adoption.

Section 7. It shall, through its officers, Advisory Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Session a stepping stone to further ones of higher interest.

Section 8. It shall consider and advise as to material interest of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse popular information in relation thereto.

Section 9. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly in-

tercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who can be made reputable, has been brought under medical society influence.

Section 10. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 11. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

Section 12. It shall upon application provide and issue charters to county societies organized to conform to the spirit of the Constitution and By-Laws.

Section 13. In sparsely settled sections two or more County Societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The County Society thus combined shall not lose any of its privileges and representation. The active members of each County Society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the State Association.

Section 14. The state shall be divided into the following councilor districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken and Marshall.

No. 2—Davies, Hancock, Henderson, McLean, Ohio, Union and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Spencer, Taylor and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalfe, Monroe, Simpson and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby and Trimble.

No. 8—Boone, Campbell and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott and Robertson.

No. 10—Fayette, Jessamine and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie and Whitley.

Councilor district meetings may be held as desired, and District Medical Associations may be organized as desired according to the districts outlined above.

Section 15. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 16. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Section 17. The complete proceedings of the House of Delegates shall be published in the Journal of the Association.

Chapter V. Election of Officers

Section 1. The President-Elect and the Vice-Presidents shall be elected for a term of one year. The Speaker and Vice-Speaker of the House of Delegates shall be elected for a term of three years. The Secretary and Treasurer shall be elected for a term of five years. The Councilors shall be elected for a term of three years and shall be limited to serving for not more than two consecutive terms. The terms shall be so arranged that one-third of the terms expire each year, insofar as possible. No member shall be eligible for the office of President, President-Elect, Vice-President, Speaker or Vice-Speaker of the House of Delegates, or Councilor who has not been an active member of the Association for at least five years.

Section 2. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting continue until an election occurs in like manner.

Section 3. Any member known to have directly or indirectly solicited votes for, or sought any office within the gift of this Association shall be ineligible for any office for two years.

Section 4. The election of officers shall be held during the closing session at the regular annual meeting of the House of Delegates.

Section 5. During the last session of the House of Delegates the Speaker of the House

of Delegates shall submit to the members of the House of Delegates a list of ten names from which by ballot the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as Chairman. The nominating committee shall submit its report in writing to all members of the House of Delegates at the first meeting of the House of Delegates and shall submit one or more names for each officer to be elected. Additional nominations may be made from the floor by submitting the nomination without discussion or comment.

Section 6. The Delegates from the counties in each Councilor District shall form the Nominating Committee for the purpose of nominating a Councilor for the Councilor District concerned. This committee shall hold a meeting open to all active members of Councilor District concerned who are in attendance at the meeting for the purpose of discussing the nomination for the Councilor to serve the District. Additional nominations may be made from the floor by any member of the House of Delegates when the Nominating Committee makes its report to the House of Delegates.

Chapter VI. Duties of Officers

Section 1. The President shall preside at all general meetings of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office and so far as practicable, shall visit by appointment, the various sections of the State and assist the Councilors in building up the county societies and in making their work more practical and useful.

Section 2. The President-Elect shall be a member of the Committee on Scientific Assembly. He shall become President of the Association at the next annual meeting of the Scientific Session following his election as President-Elect. He shall assist the President in visitation of county and other meetings and shall be ex-officio a member of the House of Delegates with the right to vote. In event of death, resignation, or if he becomes permanently disqualified, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at the next annual meeting of the Scientific Session of the Association.

Section 3. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation or re-

moval, the Council shall elect one of the Vice-Presidents to succeed him.

Section 4. The Speaker of the House of Delegates of the Association shall preside at all meetings of the House of Delegates. He shall appoint all committees for the House of Delegates with the approval of the House of Delegates. He shall be an ex-officio member of all said committees. He shall perform such other duties as custom and parliamentary usage may require.

Section 5. The Vice-Speaker shall assume the duties of the Speaker in his absence, and shall assist the Speaker in the performance of his duties. In the event of the death, resignation or removal of the Speaker, the Vice-Speaker shall automatically become Speaker of the House of Delegates.

Section 6. The Treasurer shall give bond for the trust imposed in him whenever the House of Delegates shall deem it requisite. He shall demand and receive all funds due the Association, together with the bequests and donations. He shall, under the direction of the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall in general subject to such direction have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Secretary or his Executive Secretary and shall be counter-signed by the Treasurer of the Association. Under unusual circumstances, when one or more of the above named officials are not readily available, the President of the Association or the Chairman of the Council is authorized to sign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a counter-signature. All five officials shall be required to give bond in an amount to be determined by the Council. The Treasurer shall subject his accounts to an annual audit under the direction of the Council. He shall render an annual account of his doings and the state of all Association funds.

Section 7. The Secretary, acting with the Committee on Scientific Assembly, shall prepare and issue the program for and attend all meetings of the Association and of the House of Delegates and he shall keep minutes of their respective proceedings in separate record books. He shall charge upon his books the assessments against each component county society at the end of the fiscal year; he shall collect and make proper credits for the same and perform such other duties as may be assigned him. He shall be custodian of all record books and papers belonging to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Associa-

tion which may come into his hands. He shall provide for the registration of the members and delegates at the Annual Session. He shall keep a card index register of all practitioners of the State by counties, noting on each his status in relation to his county society and upon request shall transmit a copy of this list to the American Medical Association for publication. In so far as it is in his power he shall use the printed matter, correspondence and influence of his office to aid the Councilors in the organization and improvement of the county societies and in extension of the power and usefulness of this Association. He shall conduct the official correspondence, notify members of meetings, officers of their election, and committees of their appointments and duties. He shall act as secretary of the Committee on Scientific Assembly. He shall be editor of the Kentucky Medical Journal. He shall employ such assistants as may be ordered by the Council or the House of Delegates. He shall annually make a report of his doings to the House of Delegates.

In order that the Secretary may be enabled to give that amount of his time to his duties which will permit of his becoming proficient, it is desirable that he shall receive some compensation. The amount of his salary shall be fixed by the House of Delegates.

Chapter VII. The Council

Section 1. The Council shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall consist of the duly elected councilors. The President, the President-Elect, the immediate Past-President, the Speaker and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer and the Delegates to the American Medical Association shall be ex-officio members of the Council with the right to vote. The Executive Committee of the Council shall consist of the President, the President-Elect and the Secretary of the Association, together with the Chairman of the Council, Vice-Chairman of the Council and two additional councilors to be elected annually by the Council.

Section 2. The Council shall hold daily meetings during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three councilors. It shall meet on the last day of the Annual Session of the Association for reorganization and for the outlining of the work for the ensuing year. At this meeting it shall elect a chairman and secretary, and it shall keep a permanent record

of its proceedings. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the account of the Secretary and Treasurer and other agents of this Association and shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. In the event of a vacancy in any office the Council may fill the same until the annual election.

Section 3. Each Councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his doings, and of the condition of the profession of each county in his district to each Annual Session of the House of Delegates. The necessary traveling expenses incurred by Councilor in the line of his duties herein imposed may be allowed by the House of Delegates upon a proper itemized statement, but this shall not be construed to include his expense in attending the Annual Session of the Association.

Section 4. Collectively the Council shall be the Board of Censors of the Association. It shall consider all questions involving the right and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates of the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or a county society upon which appeal is taken from the decision of an individual Councilor. Its decision in all such cases shall be final.

Section 5. The Council shall have the right to communicate the views of the profession and of the Association in regard to health, sanitation and other important matters to the public and the lay press. Such communications shall be signed by the President of the Association and the Chairman of the Council as such.

Section 6. The Council shall provide for and superintend the publication and distribution of all proceedings, transactions and memoirs of the Association and shall have authority to appoint such assistants to the editors as it deems necessary. It shall manage and conduct the Kentucky Medical Journal, which is the organ of the Association, and all money received by the Journal, the Councilor or any officer of the

Association, shall be paid to the Treasurer of the Association on the first of each month.

Section 7. All reports on scientific subjects and all scientific discussions and papers read before the Association shall be referred to the Kentucky Medical Journal for publication. The editor, with the consent of the Councilor for the District in which he resides, may curtail or abstract papers or discussions, and the Council may return any paper to its author which it may not consider suitable for publication.

Section 8. All commercial exhibits during the Annual Session shall be within the control and direction of the Council.

Chapter VIII. Committees

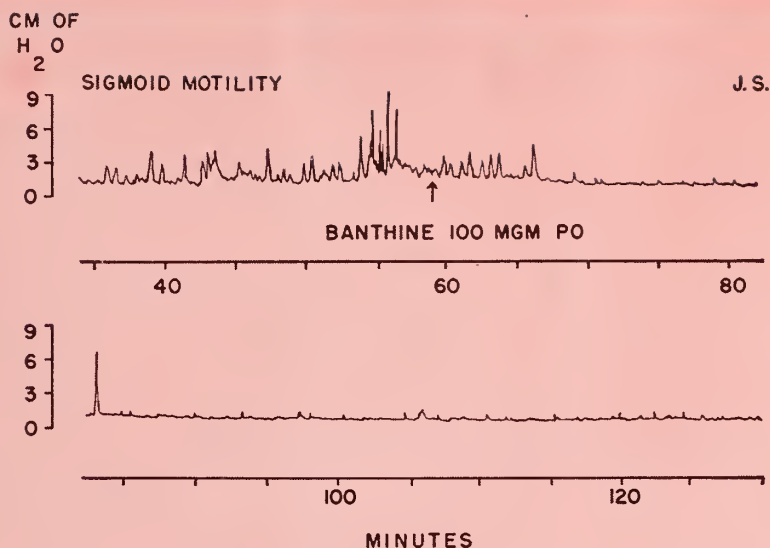
Section 1. The Standing Committees shall be as follows:

- A Committee on Arrangements
- A Committee on Scientific Assembly
- A Committee on Public Relations
- A Committee on Medical Service
- A Committee to Study Constitution and By-Laws

A Medico-Legal Committee and such other committees as may be necessary. The Headquarters Office at 620 South Third Street, Louisville 2, Kentucky, shall be the headquarters for all committees and activities of the Association except as may be specifically authorized by the Executive Committee. Committees shall be appointed by the President of the Association in conference with the Secretary unless otherwise specified. The President and the Secretary shall be ex-officio members of all committees except as otherwise specified.

Section 2. The Committee on Arrangements shall consist of as many members and subcommittees as are appointed by the President of the Association. No county medical society as such shall serve as the host society. The Chairman shall report an outline of the arrangements to the Secretary for publication in the program and shall make such announcements from time to time as may be desired. All expenses of the Committee on Arrangements shall be paid out of the funds of the Association that are made available for that purpose.

Section 3. The Committee on Scientific Assembly shall consist of five members. The President of the Association shall be a member and Chairman of the Committee. The President-Elect shall be a member of the Committee. The Secretary of the Association shall be a member and Secretary of the Committee. The President of the Association shall appoint one member for a two-year term. The Committee shall determine the character and scope



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1. Kern, F., Jr.; Almy, T. P., and Stolk, N. J.: Effects of Certain Antispasmodic Drugs on the Intact Human Colon, with Special Reference to Banthine (β -Diethylaminoethyl Xanthene-9-Carboxylate Methobromide), *Am. J. Med.* 11:67 (July) 1951.

2. Lepore, M. J.; Golden, R., and Flood, C. A.: Oral Banthine, an Effective Depressor of Gastrointestinal Motility, *Gastroenterology* 17:551 (April) 1951.

of the scientific proceedings of the Association, subject to the provisions or the instructions of the House of Delegates or of the Association or to the provisions of the Constitution and By-Laws. Thirty days previous to each annual session it shall prepare and issue a program announcing the order in which papers, discussions and other business shall be presented which shall be adhered to by the Association as nearly as practicable.

Section 4. The Committee on Public Relations shall consist of five members appointed by the Council of the Association. The members shall be appointed for a term of three years each, which shall be staggered insofar as possible. The Chairman of the Committee shall be designated by the Council. Under the direction of the Council it shall represent the Association in securing and enforcing legislation in the interest of Public Health and scientific medicine. It shall keep in touch with the profession and public opinions, shall endeavor to shape legislation so as to secure the best results for the whole people and shall utilize every organized influence in local, state and national affairs and elections. Its work shall be done with dignity becoming a great profession and with that wisdom which makes effective its work and influence. It shall have authority to be heard before the entire Association upon questions of great concern at such times as may be arranged during the annual session.

Section 5. The Committee on Medical Service shall consist of five members appointed by election of the Council. The terms of each member shall be for three years and shall be staggered insofar as possible. The Council shall annually designate the Chairman of the committee. It shall be concerned with and responsible for all matters of Medical Education and Medical Economics which shall be within the province of the State Medical Association. It shall continually strive to serve as a liaison between the public and the Medical Association in these matters.

Section 6. The Medico-Legal Committee shall consist of three members, one of whom, the Chairman, shall be elected by the Council for five years, and the Secretary and Treasurer shall be the other two members ex-officio. This Committee shall select and fix the compensation for an attorney, who shall act as general counsel, and if required, additional local counsel. The Association through this Committee shall defend its members who are in good standing against unjust suits for malpractice.

Section 7. The Committee to Study the Constitution and By-Laws shall make a constant study of the Constitution and By-Laws. The

committee shall annually make a recommendation concerning changes which it feels should be made in order to keep the Constitution and By-Laws in line with changing conditions and circumstances.

Chapter IX. Assessments and Expenditures

Section 1. The assessment of twenty five dollars per capita on the membership of the component societies is hereby made the annual dues of this Association. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association on the first day of January in each year.

Section 2. Any county society which fails to pay its assessments, or make the report required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have the prior approval of the Council before they can become effective.

Chapter X. Rules of Conduct

The principles set forth in the Principles of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

Chapter XI. Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in Robert's Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XII. County Societies

Section 1. All county societies now in affiliation with the State Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall upon application to the House of Delegates, receive a charter from and become a component part of this Association.

Section 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Charters shall be issued only upon approval of the House of Delegates and shall be signed by the President and Secretary

clinically accepted

for

increased safety

high degree of efficacy

excellent palatability


in triple

sulfonamide therapy

council-accepted

tri-sulfameth

Each 5 cc. (approx. one teaspoonful) of syrup or each tablet provides:

	Sulfamethazine	0.165 Gm.	(2.5 gr.)
	Sulfadiazine	0.165 Gm.	(2.5 gr.)
	Sulfamerazine	0.165 Gm.	(2.5 gr.)
	Sodium Citrate*	0.5 Gm.	(7.7 gr.)

*not contained in Tri-Sulfameth Tablets

"Trials of sulfonamide combinations . . . have indicated that the occurrence of crystalluria can be decreased to negligible proportions." Virginia Medical Monthly 75:56, 1949.

PROFESSIONAL SAMPLES ON REQUEST



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of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

Section 4. Only one component society shall be chartered in any county except that the House of Delegates may issue a charter to one state-wide society of worthy Negro physicians who are not members of any county society. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky State Medical Association. When more than one county society exists friendly overtures and concessions shall be made with the aid of the Councilor of the District if necessary and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Section 5. Each county society shall judge of the qualifications of its own members, but as such societies are the only portals to this Association every reputable and legally registered physician who is practicing, or who will agree to practice nonsectarian medicine shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Section 6. Any physician who may feel aggrieved by the action of the society of the county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Council, which upon a majority vote may permit him to become a member of an adjacent county society.

Section 7. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual councilors in district and county work, effort at conciliation and compromise shall precede all such hearings.

Section 8. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

Section 9. A physician living in or near a county line may hold membership in that county most convenient for him to attend, on permission of the county in whose jurisdiction he resides.

Section 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county, and systematic efforts

shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Section 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do post-graduate and original research work, and to give the society the first benefit of such labors. Official position and other references shall be unstintingly given to such members.

Section 12. At the time of the annual election of officers each component society shall elect a delegate or delegates to represent it in the House of Delegates of the Association in the proportion of one delegate to each twenty-five members or major fraction thereof. Provided, however, that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the secretary of this Association on or before April 1 of each year.

Section 13. The Secretary of each county society shall keep a roster of its members and a list of non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, on the first day of January of each year, or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Section 14. The secretary of each county society shall report to the Kentucky Medical Journal full minutes of each meeting and forward to it all scientific papers and discussions which the society shall consider worthy of publication.

Section 15. County societies may invite Dentists, Pharmacists, Funeral Directors, or other professional persons to become Associate Members of the County Society but such Associate Members shall not have any privileges or representations in the State Association.

Chapter XIII. Amendments

These By-Laws may be amended by any Annual Session by a two-thirds vote of all the delegates present at that session, after the amendment has been laid on the table for one day.

The JOURNAL *of the* Kentucky State Medical Association

ISSUED MONTHLY UNDER THE DIRECTION OF THE COUNCIL

VOL. 50

DECEMBER, 1952

NO. 12

DANIEL DRAKE MEMORIAL MEETING OF THE KENTUCKY STATE MEDICAL ASSOCIATION

Transcript of Proceedings of the Regular Session of the HOUSE OF DELEGATES

Columbia Auditorium, Louisville, Kentucky, October 7, 8, 9, 1952

(The 1951 meeting of the House of Delegates of the Kentucky State Medical Association convened at 7:15 o'clock p.m. at the Columbia Auditorium, Louisville, Kentucky, Dr. Hugh L. Houston, presiding:)

DR. HOUSTON: The House will come to order. It is the speaker's pleasure to call this, the first session of the 1952 House of Delegates, to order and in session. There was a slight error in the announcement as to the time of this meeting. Your program carries a notation of 7:30, and your booklet carries a notation of seven o'clock. It is now fifteen after seven. I would like to have a motion to allow the House to proceed with its business.

(A motion was duly made, regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: We are now in session. We will have the report from the Committee on Credentials, Dr. D. G. Miller.

DR. MILLER: Mr. Speaker, the quorum is present.

SPEAKER HOUSTON: We have been informed that a quorum is present, and that we are now ready to conduct the business of this session. We will now hear the reading of the minutes of the 1951 meeting.

(A motion to dispense with the reading of the minutes was duly made, regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered. We will now hear the list of doctors who passed on during the past year by Dr. Bruce Underwood.

DR. UNDERWOOD: Physicians who have died since 1951 annual meeting as of September 25, 1952:

Following is the name of the physician, the address and date of death:

Adams, Lynn D., Smithland, July 11, 1952

Alexander, E. R., (colored) Cynthiana, Nov. 11, 1951

Arnett, Boyd T., Madisonville, Nov. 23, 1951

Atkinson, E. B., Cane Valley, April 25, 1952

Bach, Arthur, (Member) Lexington, June 8, 1952

Bell, Francis E., Ludlow, Aug. 1952

Blair, A. L., Winchester, Jan. 6, 1952

Bushong, George Eagle, (Member) Tompkinsville, July 26, 1952

Connor, R. W., Owensboro, Oct. 1, 1951

Conrad, O. L., (Emeritus Mbr.) Breeding, Nov. 4, 1951

Cundiff, W. R., (Member) Somerset, Feb. 15, 1952

Davidson, H., Louisville, Feb. 8, 1952

Deig, Albert A., Louisville, Oct. 7, 1951

Eddy, A. Lee (Emeritus Mbr.) Louisville, May 2, 1952

Egbert, Thomas G., Clinton, May 26, 1952

Ellison, A. G., New Castle, June 30, 1952

Franz, Jesse A., (Member) Russell, July 14, 1952

Frey, E. M., (Member) Guthrie, Jan. 8, 1952

Gore, R. C., Paducah, Nov. 4, 1951

Hatcher, George E., (Member) Cerulean, May 25, 1952

Hillman, A. J., Ashland, Dec. 4, 1951

Houston, Hal E., (Member) Murray, Jan. 14, 1952

Hughes, J. T., Fountain Run, Dec. 22, 1951

Hume, Edgar E., Frankfort, Jan. 25, 1952

Hunt, H. H., Mayfield, May 29, 1952

Kenney, William J. (Member) Paris, Dec. 27, 1951

Kidd, Claude E., Paducah, May 8, 1952
 Loughridge, Cora K., Louisville, June 23, 1952
 McBee, K. S., (Member) Owenton, Sept. 18, 1952
 McCleese, Charles, Olive Hill, April 22, 1952
 Markey, James B., (Member) Hopkinsville, Nov. 2, 1951
 Merry, Charles R., (colored) Covington, May 28, 1951
 Molloy, Lee P., (Member) Paducah, April, 1952
 Montgomery, Bradley B., Lancaster, March 2, 1952
 Moore, Burt A., Louisville, Jan. 29, 1952
 Moore, Paul D., (Member) Sacramento, Dec. 21, 1951
 Moore, W. L., (Member) Madisonville, Feb. 9, 1952
 Nettleroth, Alex, (Emeritus Mbr.) Louisville, Sept. 26, 1952
 Nichols, Thomas L., (colored) Louisville, Jan. 16, 1952
 Pack, Seba E., (colored) Louisville, Feb. 2, 1952
 Phelps, R. M., (Member) Richmond, Dec. 23, 1951
 Pope, Frank W., (colored) Louisville, July 6, 1952
 Porter, R. H., Jr., (Member) Glasgow, July 18, 1952
 Powell, E. N., Corydon, June 26, 1952
 Richards, W. Clifton, (Member) Glasgow, July 30, 1952
 Richmond, O. L., Corbin, May 27, 1952
 Roberts, D. S., West Point, May 18, 1952
 Roberts, O. H., Mt. Sterling, Nov. 6, 1952
 Ruark, Rudy E., Henderson, March 4, 1952
 Russell, Clyde, (Member) Middlesboro, Sept. 7, 1951
 Shemwell, Allen H., (Member) Paducah, Feb. 12, 1952
 Sigler, L. J., Clay, May 30, 1952
 Smoot, C. E., Richmond, Oct. 24, 1951
 Snyder, O. H., (Member) Catlettsburg, Dec. 1951
 Stone, J. E., (Member) Hopkinsville, Sept. 13, 1952
 Sullivan, Robert E., Louisville, Oct. 13, 1951
 Swinford, C. L., (Member) Cynthia, Nov. 24, 1951
 Terrell, Leland L., (Member) Woodbine, April 8, 1952
 Travis, Finis M., (Member) Frankfort, July 2, 1952
 Wahle, A. J., Somerset, June 26, 1952
 Wallace, Tracy, (Member) Irvine, Aug. 16, 1952
 Watson, Ira C., (colored) Henderson, Sept. 27, 1951
 Wellman, Ira, Louisa, July 24, 1952
 Wright, W. E., Bardstown, Oct. 21, 1951
 Young, L. E., (Member) Paducah, Feb. 27, 1952

SPEAKER HOUSTON: Out of respect for these men who passed on, who have helped

medicine greatly in Kentucky, I will ask the delegates to please stand for one minute in silent tribute.

(The delegation rose for one minute of silence.)

SPEAKER HOUSTON: May I thank you. We will now have the report of the President, Dr. Clark Bailey, of Harlan. May I call your attention to the fact that your little green-backed book carries the agenda on page 11 if you want to go to it.

DR. BAILEY: Mr. Speaker, the report of the president is on file in the kit that you have, and it is respectfully submitted.

REPORT OF THE PRESIDENT TO THE

1952 SESSION OF HOUSE OF DELEGATES

The activities of the Association have been many during the past year. The majority of the County Societies have been active. Most of the committees of the Association have done excellent work. The district organizations have been active. Many of our members have given much of their time in the work of the committees of the Association.

The Legislative Committee did a marvelous task at Frankfort during the session of the 1952 Legislature, in protecting the rights of Kentucky's citizens.

The first Rural Health Conference was held under the leadership of the Committee on Rural Health.

The Emergency Medical Service Committee has a tremendous undertaking in the coordination of the program of catastrophic medicine in Kentucky with the program of Civil Defense.

Many other committees of our Association have been outstanding in their achievements. The Council and officers of the Association have been most helpful and cooperative. It is unfortunate that I do not have space to recognize all of the excellent work of our members.

It has been a pleasure, as President, to visit several County Societies and several district meetings. My experience of extensive travel over the state, meeting with the various medical groups, gives to me the conviction of a greater spirit of unity among the profession and a greater interest in its problems than ever before.

Respectfully submitted,

/s/ Clark Bailey
 Clark Bailey, Harlan
 President

SPEAKER HOUSTON: The Speaker refers the report of the President to Reference Committee No. 1.

We will now have the report of the President-Elect, Dr. R. Haynes Barr of Owensboro.

DR. BARR: Mr. Speaker, members of the

House of Delegates, the report of the President-Elect is filed and is contained in the bag of material which was handed to you.

REPORT OF THE PRESIDENT-ELECT TO THE 1952 SESSION OF HOUSE OF DELEGATES

The chief duties of the President-Elect are to render all possible assistance to the President of the Association, to represent the Kentucky State Medical Association at the request of or in the absence of the President of such Association, and to familiarize himself as thoroughly as possible with all of the administrative workings and business of the Association, in preparation for the coming year.

To this end, your President-Elect has accepted every mission assigned by our President and has tried in all ways possible to be helpful to that Officer. He has attended all meetings of the Executive Committee of the Council and all meetings of the Council during the past twelve months. The President-Elect has also attended several of the Councilor District Meetings throughout the State during that same period of time. He has also attended many of the meetings of various committees of the State Association and one conference of the American Medical Association in an adjoining state.

It has been a pleasure working with Clark Bailey, M. D., our President, during the past year. He is an excellent administrator, a great leader, and I have been greatly impressed by the veritable beehive of activity shown by members of individual committees, and the Council and the Administrative staff. I regret very much that more of the members of the Kentucky State Medical Association have not been able to observe the fine constructive work done by their colleagues on the various committees, and it is my sincere hope that with the passing of each year it will be possible to interest more of our membership in accepting assignments to active committees that they might better learn and understand the immense task confronting our State Medical Association.

Respectfully submitted,

/s/ R. Haynes Barr

R. Haynes Barr, Owensboro
President-Elect

SPEAKER HOUSTON: The Speaker refers this report to the Reference Committee No. 1 for consideration.

Now it is time for the report of the Speaker, and the appointment of these Reference Committees. The Speaker has had the pleasure of presiding over three previous sessions of this House of Delegates. He has found the delegates very cooperative and very appreciative

of his honest efforts to try to preside correctly. Last year the mechanics of the House of Delegates was so fast that a few of our delegates felt like they did not have a chance to express themselves as they wished, and we have made a considerable effort through the year to see that each delegate has been given material to explain to him in detail the workings of the House of Delegates, the workings of the Reference Committees, and the way in which business should be transacted by this body. I trust at this time that every member of this House of Delegates will feel that he has had full and ample opportunity to express himself in the way he sees fit to do so.

I have appointed and have had published in the Journal the Reference Committees that are to serve the House of Delegates. On your Reference Committee No. 1, which is to study the order and rules of business and reports of the officers and Councilors I have made these appointments: Dr. E. M. Howard, Harlan, Chairman, Dr. Laman A. Gray of Louisville, Vice-Chairman, Dr. Theodore L. Adams, Lexington, Dr. Robert L. Reeves, Paducah, and Dr. Wendell V. Lyon of Ashland.

On our Reference Committee No. 2, which is to study the reports of standing committees, I have appointed Dr. W. Vincent Pierce of Covington, Chairman, Dr. Richard G. Elliott of Louisville, Vice-Chairman, Dr. John W. Meredith, Scottsville, Dr. Robert A. Orr, Mayfield, Dr. Price Sewell, Jr., Jackson.

On Reference Committee No. 3, which is to study the reports of the special committees, I have appointed Dr. Richard J. Rust, Newport, Chairman, Dr. Gradie R. Rowntree, Louisville, Vice-Chairman, Dr. Keith P. Smith, Corbin, Dr. B. Ralph Wilson, Sharpsburg, Dr. John T. Glenn, Russellville.

On Reference Committee No. 4, which is to study the reports of the advisory committees, I have appointed Dr. George W. Pedigo, Louisville, Chairman, Dr. Frank L. Duncan, Monticello, Vice-Chairman, Dr. Leon Higdon, Paducah, Dr. T. O. Meredith, Harrodsburg, Dr. S. B. May, Eminence.

On Reference Committee No. 5, which is to study the resolutions presented to this House of Delegates tonight, I have appointed Dr. Charles B. Stacey of Pineville, Chairman, Dr. Howell J. Davis, Owensboro, Vice-Chairman, Dr. Coleman J. McDevitt, Murray, Dr. John D. Handley, Hodgenville, Dr. John W. Scott, Lexington.

On our Reference Committee No. 6, which is the Credentials Committee, I have appointed Dr. D. G. Miller, Jr., Morgantown, Chairman, Dr. Carlisle Morse, Louisville, Vice-Chairman, Dr. H. H. Rutledge, Richmond.

REPORT OF SPEAKER OF THE HOUSE OF DELEGATES TO THE 1952 SESSION OF HOUSE OF DELEGATES

This represents my second report as Speaker of your House of Delegates. The 1951 meeting of the House of Delegates was satisfactory to the great majority of the delegates representing our Association. There was some criticism pertaining to the rapidity with which the business of the House was handled. Some delegates did not feel that they understood the mechanics of our House of Delegates and, therefore, were unable to exercise their rights as delegates. These criticisms were welcomed and your Speaker and Officers have made an effort to explain the mechanics of the House of Delegates, so that future delegates will not have trouble expressed at the 1951 session.

During the past year it has been my duty to again work with the Central Office in encouraging the county societies to elect their delegates early and to take an active part in the planning for this meeting and in the affairs of our Association.

The Speaker has appointed the Nominating Committee and five Reference Committees. These nominations were made well in advance of this meeting and were published in the State Journal. I have used my very best judgment in the appointing of these committees and I do trust that they will serve the Association in a way pleasing to the majority of our members. Again allow me to remind you that our new Constitution has taken a great deal of authority away from the Officers and the two meetings of the House of Delegates and assigned these duties to the Reference Committees. Please carry your discussion on vital problems before the committees assigned to study and recommend solutions for these problems.

Your Speaker wishes here to invite the active participation of all delegates in the affairs of the Association. May each member of the House of Delegates find me fair and unbiased and forever conscious of the will of the elected Delegates of the Kentucky State Medical Association.

Respectfully submitted,

/s/ Hugh L. Houston

Hugh L. Houston, Murray

Speaker of the House of Delegates

I would like to have a motion approving my appointments on the Reference Committees, and also the power to fill any vacancies that may occur in these Reference Committees during this session of the 1952 House of Delegates.

(A motion was duly made, regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered. I would remind the Reference Committees to read carefully the instructions in the manual about their time of meeting, their length of meeting, and

their attention they are to give to the duly-elected Delegates of this Association.

We will now have the report and recommendations of the Council by Dr. Clyde C. Sparks of Ashland, Chairman of our Council.

REPORT OF THE COUNCIL TO THE

1952 SESSION OF HOUSE OF DELEGATES

DR. SPARKS: Mr. Speaker, Members of the House of Delegates. If you will study the report of the secretary and general manager, which probably will not be read in detail unless it is requested, you will note that the method of operation of the Council was changed according to the wishes and instructions of the House of Delegates. This is the first year that we have operated under this new regime. We of the Council want more and more the House of Delegates to feel that this is their organization and that such policies as are made by the Council when the House of Delegates is not in session should be directed by the individual component societies through their Councilor in order that their wishes may be done by the Council as a group.

This year the cooperation of all of the members of the Council has been most gratifying. The method of operation, briefly, is an Executive Committee of our Council receives the information or the subjects to be considered first. They study these rather exhaustively and bring back to the Council certain recommendations. Sometimes they are accepted, sometimes they are not. The Council therefore has more time to consider the more serious questions, and that will be borne out as I read to you their report. But please bear in mind that with the Council when it is reorganized on this Thursday it becomes your Council and it is your duty to medicine to see that this Council expresses your wishes.

The Council held its first meeting of the 1951-52 year on October 4, following the second meeting of the House of Delegates, Wednesday, October 3, at which time three new Councilors had been elected. They are: Walter L. O'Nan, M. D., from the Second District; L. O. Toomey, M. D., from Sixth District; and Edward Wilson, M. D., from the Fifteenth District. Bruce Underwood, M. D., serving as temporary Chairman, called the meeting to order. He explained the changes in the By-Laws, enacted by the House of Delegates the evening before, which provided for the Council to appoint the Committee on Medical Service and the Public Relations Committee as standing committees. Other standing committees appointed by the Council, he said, were the Advisory Committee to the Editor, the Legislative Committee and the Education Campaign Committee.

The function of the enlarged Executive Committee of the Council, which was also provided for by the House of Delegates action the night before through changes in the By-Laws, was explained by Dr. Underwood. It was moved and seconded that the new Executive Committee make nominations for the five committees outlined above and present these nominations at the next meeting of the Council. The motion carried.

C. C. Sparks, M. D., was then unanimously elected Chairman of the Council. J. Farra Van Meter, M. D., Vice-Chairman, and Bruce Underwood, M. D., General Manager of the Council. The Council then elected B. B. Baughman, M. D., and R. R. Slucher, M. D., as the other members of the Executive Committee, the By-Laws providing that the President of the Association, the Chairman of the Council and the Secretary and General Manager also serve.

The Council authorized its Executive Committee to study the re-arrangement of expiration of councilor terms of office, so that five councilors would be elected each year. This had previously been provided for in the By-Laws, but it wasn't working out that way, and you will have a resolution on that from your Committee on the Constitution and By-Laws during the evening. It tabled the matter of paying the traveling expenses of the Councilors to meetings of the Executive Committee and Council, and authorized the Executive Committee to study the matter of the Association making a contribution to the National Education Foundation Fund.

The new President, Clark Bailey, M. D., stated briefly his plans for the 1952 Annual Meeting. At this time, the Council voted to give Doctor Bailey and the Committee on Scientific Assembly complete freedom in the selection of the essayists and to memorialize Daniel Drake, M. D., at the 1952 Meeting, as 1952 is the centennial of Doctor Drake's death. It was decided the next meeting of the Council would be held December 27, 1951.

(At the September 11, 1952 meeting of the Council, it was decided that, inasmuch as the Executive Committee is a committee of the Council, the Executive Committee would not make a report—but that its actions be reported as actions of the Council. The Executive Committee held meetings on November 1, 1951; December 6, 1951; January 24, 1952; April 3, 1952; May 8, 1952; July 17, 1952; and September 4, 1952. The Executive Committee limits itself to three kinds of actions: Positive actions, which are final, recommendations to the Council and refusal to consider a matter.)

SECOND MEETING. This session was held in the Headquarters Office December 27. The

Secretary and General Manager, in his report, explained some of the actions of the A.M.A. Clinical Session held earlier in the month at Los Angeles, stated the House of Delegates acted in harmony and that a joint commission on hospital accreditation had been set up on a national basis. Doctor Underwood told of the meeting he and Doctor Bailey, the President, had attended at the Fayette County Medical Society in which K.S.M.A. policies and operations were explained. Concluding his report, Doctor Underwood said: "As of this meeting I am now able to say that the affairs of the Kentucky State Medical Association are entirely in the hands of the Association's officers and elected representatives and that the Headquarters Office is no longer setting policy."

I think that is particularly important in the light of the opening remarks that I made, getting the doctors at the local level to take an active part.

The Executive Assistant, among other things, reported that the Executive Committee had approved the program for the County Society Officers Conference for February 7, 1952, that the Association had received a check for \$1500 from A. Clayton McCarty, M. D., Chairman of the Advisory Committee to Selective Service, to cover services rendered to the Committee by the Headquarters Office prior to July 1, 1951, and that Selective Service was now contributing stamps, stationery, telephone and telegraphic expenses and that it was making a contribution to the salary of one of the Headquarters Office employees.

The Council approved the recommendations of the Executive Committee with respect to the personnel of the Editorial Advisory Committee, Legislative Committee, Public Relations Committee and the Committee on Medical Service. The Council was told the Education Campaign Committee Chairman had been selected but that its personnel had not been chosen. The Executive Committee recommendation to the Council that the new statewide component medical society for colored physicians, who resided in counties where county medical societies had not voted to accept the colored doctors, would be called the Commonwealth Medical Society, was accepted. It was pointed out that members of this society would be represented in the House of Delegates, on the same basis as members of the component county societies, and that they would operate under the model county constitution and by-laws.

The Council accepted Executive Committee recommendations that the Rural Health Conference be sponsored by the Committee on Rural Health; that the Association was not in

a financial position to contribute to the A.M.A. Medical Education Foundation; that it disapproved of the brochure printed by the Kentucky Child Health Foundation and entitled "Can I Grow Up Strong and Healthy in Kentucky?", and that each county medical society that did not have the provision in its by-laws to change them in order that local members of the Kentucky State Dental Association might hold associate memberships in their county medical society and the K.S.M.A.

Activities, responsibilities and authority of the Legislative Committee were discussed at length, after the recommendation of the Executive Committee was read. These recommendations included the following: That the Legislative Committee be authorized to act on behalf of the Association during the coming 1952 Legislative Session, that Doctor Underwood be made a member of the Committee, and, that due to Doctor Houston's geographical location, Doctor Baughman be named Co-Chairman of the Legislative Committee. It was also proposed that Doctors Houston and Baughman be authorized to consult with President Clark Bailey on matters of policy interpretations. These recommendations were accepted by the Council, except it was agreed that Doctor Underwood would be an ex-officio member of the Legislative Committee rather than a full member—the latter being done at Doctor Underwood's request. Accepting the recommendation of the Executive Committee, the Council voted to ask the Committee on Revision of the By-Laws to make recommendations to the House of Delegates on the revision of councilor terms, in order that five terms might expire each year.

Now as I go on with this report, you will probably find that on certain occasions I will leave out certain paragraphs or certain portions. Subsequent actions of the Council since this report was typed have made that necessary.

The Chairman of the Council explained that the Executive Committee had voted to ask the A.M.A. House of Delegates to relax its rule that no member of a state association in good standing in 1950 could join the A.M.A. after 1950 until 1950 A.M.A. dues had been paid. He said Kentucky's A.M.A. Delegate, J. Duffy Hancock, M. D., had been asked to present the resolution at the Los Angeles meeting and that Doctor Hancock was now ready to report. Doctor Hancock said the resolution did not pass, but a compromise resolution, authorizing the A.M.A. Secretary and General Manager to "negotiate" with the respective state associations on this issue and work out a satisfactory arrangement, had been passed by the House of

Delegates, and that he felt the purpose of the Executive Committee resolution had been accomplished. Doctor Hancock also reported as Chairman of the committee to stimulate K.S.M.A. members to contribute to the A.M.A. Education Foundation. Doctor Hancock said he felt it was important that this Association's members pay A.M.A. dues first, and that after April 1 he expected to become active in promoting his committee's work. The Council accepted Doctor Hancock's reports.

The report of the Legislative Committee was read and discussed. Each of the recommendations of the Legislative Committee were read and carefully discussed. Action was taken by the Council on the following Legislative Committee proposals: (1) That the Medical Practice Act be approved as changed—(accepted by the Council); (2) That as soon as the recommendations of the Functions and Resources Committee of the State of Kentucky has reported, and if no recommendations on indigent medical care were proposed by it, the Council recommend a Planning Commission be set up and funds be provided to finance its studies to be proposed at the 1954 Session of the Legislature—the recommendation was approved; (3) That Mr. Goodlett, the Association Attorney, be authorized to draw up a bill that would require all persons entering any branch of the healing arts have at least two years training in an accredited college—(accepted); (4) That the Council go on record, but not actively campaign for at this time, the principle of earmarked taxes for the support of education, health and state operated hospitals—(accepted); (5) It was agreed to distribute copies of the proposed Medical Practice Act, on request; (6) The Council went on record as approving the passage of the proposed Titles Act and the Narcotic Act.

Dean Murray Kinsman of the University of Louisville School of Medicine reported that he had held several conferences with Mayor Charles Farnsley of Louisville, relative to the expansion of facilities at the Medical School to train more physicians and that he had been authorized by the Mayor to obtain estimates on the proposed construction called for under the expansion plans.

It was agreed that the Headquarters Office would provide the Councilors with names of new physicians that located in the respective districts that the Headquarters Office had records of.

President Bailey in his report spoke of his many activities and received Council approval to invite eleven or twelve outstanding nationally known guest speakers to appear on the scientific program at the 1952 Annual Session.

Doctor Bailey made a strong appeal to the Councilors to support the Association's Legislative Program and to attend the meeting of the County Society Officers Conference February 7.

THIRD MEETING. This session was held at the Brown Hotel, the afternoon of May 8, following the Rural Health Conference. It was explained that the reports of the staff members of the Headquarters Office had been mimeographed and mailed to the Councilors and that they would be filed with the minutes of this meeting. This was being done in order to save the Councilors time at this meeting.

President Bailey, in his report to the Council, listed the meetings he had attended, commented on the success of the telephone seminars and noted, with pleasure and satisfaction, the increased activity of the K.S.M.A. committees.

The positive actions taken by the Executive Committee since the December 27 meeting of the Council were reported as follows: The sending of a letter to each colored physician in the state explaining the action of the 1951 House of Delegates on the proposal to admit colored physicians; date of the 1953 Annual Meeting changed from October 6, 7 and 8 to September 22, 23 and 24, because of conflicts with other meetings; authorizations for a K.S.M.A. booth at the Kentucky Education Association meeting and a \$200.00 appropriation to cover Rural Health Conference expenses; raising the subscription fee of the Journal of the K.S.M.A. from \$5.00 to \$8.00 per year, because of increased production costs; approval of Editorial Advisory Committee recommendation that the department in the Journal publishing reports of county medical societies be edited to include only the meat of the report; and that the date of the 1953 County Society Officers Conference be set for March 5.

The Council acted as follows on the Executive Committee recommendations: (1) That the Association not endorse any one company's policy of hospital and medical care but rather endorse and encourage the support of the principle of prepayment insurance generally—(accepted); (2) Relative to the matter of the operation of laboratories by technicians not supervised by regularly licensed physicians, the Council voted to go on record as disapproving the practice and if and when the operation of a laboratory not supervised by a licensed physician involves the practice of medicine, the matter be referred to the State Board of Health; (3) On the matter of Executive Com-

mittee minutes, the Council voted to authorize the Headquarters Office to process and mail to the members of the Council the minutes of their meetings, prior to the next meeting of the Council; (4) Recommendation that the reports of officers and committees to the House of Delegates be mailed to the delegates two weeks before the first meeting of the House of Delegates, and that a list be enclosed of any officer or committee chairman who had not submitted his report in time to be processed and enclosed in the mailing, was accepted by the Council.

The last recommendation provoked further discussion on the matter and it was duly moved, seconded and carried that any report the House of Delegates requested should be read and that the Reference Committee reviewing the reports should, in its report back to the House of Delegates, include a digest of each report submitted. (5) The recommendation that the Nominating Committee go into session immediately after the first session of the House of Delegates ends to receive nominations, and that it report at the start of the second scientific session at 2:00 p.m., Tuesday afternoon, October 7, was approved; (6) The Council also accepted the recommendation from the Executive Committee that the Council go on record as approving the Red Cross Bloodmobile program; (7) The Council accepted the recommendations for the completion of the personnel for the Education Campaign Committee previously unappointed and the Executive Committee's recommendation of three men each for each of the four posts on the new Hospital Advisory Council, the fifth member physician to be the Health Commissioner, as provided for in the Hospital Licensure Act; (8) The Council approved the Executive Committee recommendation that the Telephone Seminars be continued and that programs be held in each of four months—January, February, March and April; (9) The proposal that regulations modifying Blue Cross practices, with respect to paying certain physicians' fees, be referred to the Committee on Medical Service for study and report back to the Executive Committee; (10) The nominations to the Governor for three names for each of the three posts on the Medical Research Commission were accepted.

The next two pages I do not wish to read, because they do constitute the budget, which has been approved by the Council. They are figures. They are available there for your study.

APPROVED K.S.M.A. BUDGET FOR FISCAL YEAR

July 1, 1952 - June 30, 1953

ESTIMATED ASSETS AS OF JULY 1, 1952

CASH IN BANKS	\$ 40,025.00
Checking Account	\$ 5,025.00
Savings Accounts	35,000.00
INVESTMENTS—AT COST	32,236.52
U. S. Government Bonds	\$31,481.00
Louisville Title Mortgage Co. Common Stock.....	755.52
ACCOUNTS RECEIVABLE—ADVERTISING.....	1,025.00
TOTAL CASH AND INVESTED RESERVES.....	\$ 73,286.52
PROPERTY	\$35,090.00
McDowell House—at appraised value.....	\$25,000.00
McDowell Home Furnishings—at appraised value.....	5,000.00
Library—Estimated Value	480.00
Office Equipment—Depreciated value	4,610.00
TOTAL OF ALL ESTIMATED ASSETS.....	\$108,376.52

ESTIMATED INCOME AND EXPENSES, JULY 1, 1952 - JUNE 30, 1953

	Estimated Income	Estimated Expenses
ITEM I—Current Fund Account	\$ 50,540.00	\$ 46,115.00
ITEM II—Journal Account	15,000.00	15,070.00
ITEM III—Annual Meeting Account	8,385.00	8,925.00
ITEM IV—Annual County Society Officers Conference Account00	300.00
ITEM V—Officers, Delegates, Councilors and Miscellaneous Committee Expense Account.....	.00	1,450.00
ITEM VI—Medico-Legal Committee Expense Account (Included in Item V in 1951-1952).....	.00	770.00
ITEM VII—Promotional Expense Account (Formerly Educational Campaign Committee Expense Account).....	.00	2,000.00
EXPENSES		
1. Public Relations Committee	\$666.66	
2. Legislative Committee	666.67	
3. Educational Campaign Committee	666.67	
ITEM VIII—Postgraduate Education Account.....	.00	1,000.00
ITEM IX—Rural Health Program Account.....	.00	200.00
ITEM X—Diabetic Detection Program Account.....	.00	100.00
ITEM XI—Woman's Auxiliary Account00	500.00
TOTAL BUDGET EXPENSES		\$ 76,430.00
TOTAL BUDGET INCOME		73,925.00
DEFICIT		\$ 2,505.00

FOURTH MEETING. The fourth meeting was held in Headquarters Office on September 11. President Bailey gave a brief report of the many activities he had engaged in since the last meeting of the Council and called attention to the features and highlights of the 1952 scientific program and other portions of the Annual Meeting. He said he and his committees felt this would be an unusually good Annual Session.

The Secretary and General Manager commented on: (1) The State Board of Health's acceptance of the Executive Committee recommendations that Articles 1, 4 and 5 of the proposed Code of Professional Conduct be adopted as the code for the time being; (2) The Executive Committee had accepted his recommendation that a new letterhead be used by the Association, which letterhead would not be confused with the one used by the State Depart-

ment of Health, and his recommendation to the Executive Committee that the title of the Executive Assistant be changed to Executive Secretary.

At this time, the Executive Secretary commented briefly on the plans to emphasize Civil Defense at the Public Meeting and the Scientific Session and that the television and radio stations were arranging public service time for use by notables here for the Annual Meeting.

Other positive actions taken by the Executive Committee since the May 8 meeting of the Council included: (1) Date of the 1954 Annual Meeting was set for September 21, 22 and 23; (2) The School Health Committee was authorized to explore the possibility of having a school health conference and report back to the Executive Committee; (3) The Medical Practice Committee asked to conduct a survey of the corporate practice of medicine in Kentucky; (4) The President was authorized to appoint an Advisory Committee to Blue Cross; (5) Directed the Secretary to forward to Emmet F. Horine, M. D., an official expression of the Association's appreciation for his work in editing the Centennial Volume; (6) Directed the Association's Attorney, Vincent Goodlett, to look into the law, with the view of finding ways to secure state financial support to the Medical School in a more satisfactory way; (7) Approved that the Council will make its report to the House of Delegates in chronological order, with a summary of its actions for the year being made at the end of the report; (8) Authorized the Chairman of the Council and the Speaker of the House of Delegates to select the reports to be read before the House of Delegates other than those ordered in the By-Laws; (9) Authorized Officers of the Association to talk with representatives of the A.M.A. attending the Charleston conference on medical care, September 6, relative to financial assistance in the proposed medical care survey and report back to the Council; (10) Set up recommendations for personnel of standing committees the Council appoints, for consideration of the new Council at its first meeting October 9 (the purpose of this being to allow the committees to function without interruption or the uncertainty of waiting until the December Council meeting to know their status); (11) Authorized the transfer of funds appropriated for use by the McDowell House from the Committee Account to the Account of the Board of Directors, as the committee no longer functions as such.

The recommendations to the Council by the Executive Committee were: (a) That a coordinated Council for Tuberculosis Control be set up for the purpose of coordinating the activities of the Tuberculosis Sanatoria Commission, the State Board of Health, the Tuberculosis As-

sociation and the Kentucky State Medical Association, with two representatives from each organization making up the Coordinated Council. The following motion was passed by the Council: "That the State Medical Association participate in the Coordinated Council for Tuberculosis Control and cooperate with the Tuberculosis Sanatoria Commission, the State Board of Health and the Tuberculosis Association, by having the Chairman and one other member of the Advisory Committee on Tuberculosis of this Association appointed by the President, serve as the representatives of the Association on that Council; provided, further, that the appointing authority observe the necessary caution that representatives of the State Association not be officers or prominently identified with any of the other coordinating agencies on that Council." (b) Similar recommendations were made for coordinating councils for Heart Disease Control and Cancer Control. In this case, however, only three organizations will participate; for the Heart Control Council, member organizations being the Kentucky Heart Association, the State Board of Health and the K.S.M.A.; and for the Cancer Control Council, the Kentucky Chapter of the American Cancer Society, the State Board of Health and the K.S.M.A. The Council adopted the same motion authorizing K.S.M.A. participation in the Heart and Cancer Controls as used in the TB Control under (a) listed above. (c) It was recommended that the Association become active in the seeking of legislation implementing the Medical Examiner Coroner System in Kentucky and that the Association appoint a committee to meet with the coroners, with the view of agreeing on a program, and that said committee would report back to the Executive Committee. The recommendation was accepted. (d) The Council accepted the recommendation from the Executive Committee that County Medical Societies be urged to consider the recommendation: that no member be elected to the office of County Medical Society Secretary until he had been a member of it for two years, and that once elected he would serve a three-year term. Included in the recommendation, which is to be presented to the House of Delegates as a resolution from the Council, is a provision that this is permissive and does not in any way bind the County Medical Society. (e) The Executive Committee recommendation to the Council that a resolution be presented to the House of Delegates asking the House to grant a charter to the newly formed colored statewide component medical society, as provided for in the By-Laws, was approved. The name of the new colored group is the Commonwealth Component Medical Society. (f) The Council considered the re-

port of the Committee on Medical Service Action of the Executive Committee, relative to this Association seeking assistance from the Council on Medical Service of the A.M.A. in the making of a survey of the medical care of the indigent and the medically indigent in the State of Kentucky, for the purpose of obtaining a true picture of Kentucky's problem. The Council's only action was that the A.M.A. Council on Medical Service be contacted in writing; that their cooperation be sought in studying the matter to the extent of making proposal of joint participation of the two organizations in the making of the survey. (The Council was told the A.M.A. group would meet the latter part of September 1952.) (g) A recommendation of the K.S.M.A. Dental Committee, which had been considered and approved by the Executive Committee, with the recommendation that the Council consider it, and if it was acceptable, pass it on to the House of Delegates, was approved. Provisions of the recommendations of the Liaison Committee are as follows:

1. That county medical societies and dentists in the community have, at least, one joint scientific meeting every year, in which matters of mutual interest would be treated by a competent essayist.

2. That some type of joint meeting (possibly including the wives and families of the physicians and dentists) of a social nature be held once a year.

3. That physicians and dentists in the local community collaborate in the solving of local public health problems.

4. That the dentists be asked to participate in all local civil defense plans.

5. That the dentists be asked to participate and cooperate in the Diabetic Detection Drive held each November.

6. That the dentists be asked to support the Rural Health Movement and cooperate with the physicians in sponsoring and providing leadership for such efforts.

7. That physicians and dentists united their efforts in attempting to get all persons involved in health service, including their own families, and employees registered and see that they vote in each election.

8. That the two professions explore areas in which they could cooperate in solving public relations problems that might exist at the local level.

(h) The recommendation of the Executive Committee to the Council that the following three names of physicians be submitted to the Governor in accordance with KRS 211-040, one of which would be appointed by the Governor to fill the vacancy on the State Board of Health occasioned by the recent death of F. M. Travis, M. D. The names recommended were: Thomas

Leonard, M. D., Frankfort; William S. Snyder, M. D., and Coleman Johnston, M. D., Lexington. The Council accepted the recommendation. (i) The Council approved the recommendation of the Executive Committee that the House of Delegates, at some time during its two sessions to be held during the 1952 Annual Meeting, go into executive session for the purpose of granting Doctor Underwood an opportunity to discuss narcotic addiction and medical practice act violations, and J. B. Lukins, M. D., Chairman of the Committee on Medical Practice, to discuss the general subject of the corporate practice of medicine in Kentucky. (j) The Executive Committee passed on to the Council a recommendation of the Kentucky Advisory Committee to Selective Service, urging the appointment of a K.S.M.A. Physicians Placement Committee. The Council voted to authorize the committee, which would be appointed as follows: Each Councilor would name one man from his district to serve on the 15-man committee, with the President of the Association naming one of the 15 men as Chairman. The Council further authorized this Committee to work and cooperate with the Physicians' Placement Service operated by the State Department of Health. (k) The Council agreed to refer the Executive Committee recommendation: that the Journal publish a list of the communities needing physicians, as a result of their doctors being called into the Armed Forces, over to the new K.S.M.A. Physicians' Placement Committee, authorized under (i) for action. (l) The Council postponed action on the Executive Committee recommendation relative to the matter of taking steps to prevent certain members of the so-called "healing arts" group not licensed to practice medicine from purchasing and dispensing drugs until more information could become available.

Under the heading of new business, President Bailey discussed the importance of obtaining a well-trained man to represent the Association as Field Secretary, and asked the Council to increase the amount budgeted for this position. After discussion, the Council voted to authorize an annual salary of \$5500.00 for this post.

Activities of the Special Committee on Medical Education were reported on by Chairman Sam Overstreet, M. D. The efforts put forth by Mayor Farnsley to live up to the City's part of the agreement to expand facilities at the University of Louisville School of Medicine, in order to accept additional students and the dis-appointments encountered, were discussed by Doctor Overstreet. The Council voted to express its appreciation to the Committee and asked it to keep the Council informed of developments in this field.

Doctor Barr called the attention of the Council to the activities of the International Labor Organization, a section of the United Nations, and the provision that any treaty sponsored by the I.L.O. and ratified by the United States superseded the established laws of the land. He pointed out that one treaty promoted by this section of the U. N. endorses compulsory health insurance, and asked the Council to take a stand on this matter. The Council passed the following motion: "That action be taken opposing this move by the House of Delegates at the 1952 Session and that the senators and members of the House of Representatives from Kentucky be informed of this action."

There will be a resolution in a few minutes on that.

The Council was informed that the K.S.M.A. Committee on the Training of Ambulance Attendants had gone to considerable effort in preparing a manual designed to train ambulance attendants in the emergency care of the sick and wounded, that the Executive Committee had approved the manual for publication by funds budgeted for the Public Relations Committee of the Association, with the provision that the manual be approved, first, by the Editorial Advisory Committee. It was also stated that the Editorial Advisory Committee had referred the manual to an especially appointed consultant, that the consultant's report had not been received until two days before the Council met, that the Editorial Advisory Committee as a result of receiving the consultant's report at such a late date had not had time to meet and consider the report, and that, because it was understood the Committee on the Training of Ambulance Attendants was anxious to have an early report, the Editorial Advisory Committee was submitting the report of the special consultant to the Council without recommendation for action by the Council. After lengthy and careful consideration, the Council passed the following motion: "That the Chairman of the Committee for the Training of Ambulance Attendants be informed that the Council had made a careful study of the products of the Committee's efforts, and it is the opinion of the Council, for the sake of uniformity, maximum use be made of the Red Cross First Aid Manual, that it be distributed to all ambulance attendants and that neither the Council nor any of its committees be authorized to publish any manual."

A resolution of the Fayette County Medical Society was presented to the Council. The resolution questioned the practice of certain awards by living members of the Association. The Council approved the following motion on this matter: "That because of doubt of the origin of these awards (whether they origi-

nated in the Council or the House of Delegates) the resolution of the Fayette County Medical Society be passed to the House of Delegates at its 1952 session without recommendation." Names of members submitted as nominees for the three 1952 awards were read. It was taken by consent that action on this matter be deferred until the next meeting of the Council.

There was a discussion concerning the matter of whether Blue Cross should be authorized to pay for out-patient care in hospitals that did not actually require hospitalization. The matter was referred to the newly-authorized Advisory Committee to Blue Cross, for study and recommendations.

Summary of the more important policy actions of the Council taken during the period October 4, 1951 through September 11, 1952.

1. Granting the President of the Association a free hand in the selection of the best talent available for the presentation of the scientific program at the Annual Meeting.

2. Authorized the First Rural Health Conference.

3. Authorized the Legislative Committee to speak for the Association during the 1952 Session of the General Assembly.

4. All-out legislative support of certain proposed health measures.

5. Opposing operation of laboratories not supervised by a licensed physician.

6. With respect to the activities related to the operation of the House of Delegates—

- a. Mailing reports of committees and officers to House members two weeks before the House convenes.

- b. Providing for early meeting and reporting of the Nominating Committee.

- c. Other procedures designed to acquaint members of the House with information on resolutions, etc.

7. K.S.M.A. participation in proposed coordinated councils for the control of Tuberculosis, Heart Disease and Cancer.

8. That County Medical Societies favorably consider requiring all members elected as Secretary to have been a member for two years prior to the election and that the Secretary serve a three-year term.

9. Took strong stand against certain treaty proposals the International Labor Organization, a section of the U. N., was urging on Congress.

Respectfully submitted,

/s/ Clyde C. Sparks

Clyde C. Sparks, M. D.

Chairman

Mr. Speaker, this is the report of the Council with certain recommendations. There are certain other resolutions that the Council should include in that. Mr. Speaker, with your per-

mission I will do that now. They have been mentioned in the course of the report, but I would like to read them.

RESOLUTION TO THE 1952 SESSION OF HOUSE OF DELEGATES

WHEREAS, the office of Secretary is of vital importance to the proper functioning of a County Medical Society;

WHEREAS, a period of time is required to learn how to best carry out the duties and responsibilities of that office;

NOW THEREFORE, be it resolved by this House of Delegates that all county societies be urged to give consideration to the desirability of electing their secretaries to serve for a term of three years rather than for one year, and that no member be eligible to be secretary until he has been a member of the Society for at least two consecutive years.

Respectfully submitted,
COUNCIL OF THE KENTUCKY
STATE MEDICAL ASSOCIATION
/s/ C. C. Sparks
Clyde C. Sparks, Ashland
Chairman

RESOLUTION TO THE 1952 SESSION OF HOUSE OF DELEGATES

WHEREAS, the K.S.M.A. Dental Committee is a duly constituted agency of this Association and is charged with the responsibility of promoting better relations between the dental and medical professions;

WHEREAS, the Committee, after careful study, feels that the most effective place to undertake to improve these relations is at the county level;

WHEREAS, the Committee has drafted certain proposals that are designed to help accomplish its objectives;

WHEREAS, the Executive Committee and the Council have approved these projects and have recommended that they become the policy of this Association;

NOW THEREFORE, be it resolved that the House of Delegates approve the recommendations of the Council and the 8 points listed below.

1. That County Medical Societies and dentists in the community have at least one joint scientific meeting every year, in which matters of mutual interest would be treated by a competent essayist.
2. That some type of joint meeting (possibly including the wives and families of the physicians and dentists) of a social nature be held once a year.
3. That physicians and dentists in the local community collaborate in the solving of local public health problems.

4. That the dentists be asked to participate in all local civil defense plans.
5. That the dentists be asked to participate and cooperate in the Diabetic Detection Drive held each November.
6. That the dentists be asked to support the Rural Health Movement and cooperate with the physicians in sponsoring and providing leadership for such efforts.
7. That physicians and dentists unite their efforts in attempting to get all persons involved in health service, including their own families, and employees, registered and see that they vote in each election.
8. That the two professions explore areas in which they could cooperate in solving public relations problems that might exist at the local level.

Respectfully submitted,
COUNCIL OF THE KENTUCKY
STATE MEDICAL ASSOCIATION
/s/ C. C. Sparks
Clyde C. Sparks, Ashland
Chairman

RESOLUTION TO THE 1952 SESSION OF HOUSE OF DELEGATES

WHEREAS, the International Labor Organization is a section of the United Nations;

WHEREAS, treaties drafted by the I. L. O. and ratified by Congress supercede the laws of the land;

WHEREAS, the International Labor Organization strongly supports the principles of compulsory health insurance and socialized medicine, and has incorporated these principles in the treaty now submitted to this country for ratification;

NOW THEREFORE, be it resolved that the House of Delegates of this Association take a strong stand against the ratification of this treaty and notify the Senators and Congressmen from Kentucky of its vigorous opposition.

Respectfully submitted,
COUNCIL OF THE KENTUCKY
STATE MEDICAL ASSOCIATION
/s/ C. C. Sparks
Clyde C. Sparks, Ashland
Chairman

Mr. Speaker, speaking for the Council, I would like to request for three items of business at the close of this session of this House of Delegates that we go into executive session.

SPEAKER HOUSTON: We have received the report and recommendations of the Council in two parts. The report and recommendations that you have heard are now being referred to Reference Committee No. 1 for discussion. I feel sure that many of you delegates have something to say about many of the points that Dr. Sparks has read tonight. The Reference Com-

mittee is the place to start the discussion on these points, and they will welcome you tomorrow afternoon at two o'clock for this discussion.

Now the Chairman of the Council has requested that the House of Delegates go into executive session at the end of this meeting. The Chair asks for a motion from you allowing him the privilege to hold that executive session.

(A motion was duly made, regularly seconded, and was put to vote and carried.)

SPEAKER HOUSTON: The Chair will call an executive session at the end of this meeting for the Chairman of the Council to explain the three resolutions that he wishes to discuss with the House of Delegates.

We will now have the nomination and selection of the award recipients for the three medals. First, the Distinguished Service Award, second, the E. M. Howard Award, and third, the J. Watts Stovall Award. I would like to ask the privilege of the House of Delegates to spread among you one ballot where you will have a chance to vote for each of the nominees.

DR. E. M. HOWARD: Members of the House of Delegates of the Kentucky State Medical Association. There is a matter I want to speak to you about these awards. There has been some fault found with the awards by one medical society in the state, Fayette County. It seems that they are objectionable in some way to them, some of the awards are, the method or the manner in which they have been handled, and they think there are too many awards. I believe, after considering that matter, and after an invitation this afternoon at a session with the general officers and members of the Kentucky Academy for General Practice, inviting me and requesting me to transfer my award to their society, their Association, and after giving it some thought I have decided to do that, and my award will be transferred to the Kentucky Academy of General Practice at their voluntary request. I do this because I think our Association is much bigger than any component section or anybody, and for that reason, to promote harmony, I believe it would be the best thing to do. I hope that will meet with the approval of the House of Delegates. I think it will be given at the April meeting of this association of general practitioners.

In connection with this Distinguished Service Award, I was notified by a good friend of mine that I would be nominated for that, and I hastily wrote a request that I be not nominated. I understand Dr. O'Nan is to be nominated. He is an excellent gentleman and a fine doctor and worthy of the medal, and if he receives it I think it will meet with my approval whole-heartedly. Thank you.

SPEAKER HOUSTON: Thank you, Dr. Howard. Let me get the ballots out in the House and get a teller for this election.

(Three tellers were appointed by the Speaker to spread the ballots.)

DR. SPARKS: Mr. Speaker, your Council has been handed these names for nomination for the Distinguished Service Medal. We have the name of Dr. E. M. Howard, Harlan, Kentucky, and the name of Dr. Walter O'Nan of Henderson, Kentucky. We have no nominations for the E. M. Howard Award.

For the J. Watts Stovall Award, your Council has been presented three names which we pass on to the House of Delegates for their consideration: Dr. David Arthur Bates, Louisville, Kentucky, Dr. C. H. Jones, Calloway County—no, that's where he was born—Dr. C. L. Sherman of Millwood, Kentucky. We have those three names for the J. Watts Stovall Award.

SPEAKER HOUSTON: The Speaker has two names for the Distinguished Service Award. They are Dr. E. M. Howard of Harlan—and you have heard Dr. Howard's discussion on this matter. The Speaker has no power to act as he wishes, but must place his name for the voting, and Dr. O'Nan of Henderson. I will ask you to please vote for one of these two men for the Distinguished Service Award on your ballot. There are no nominations for the E. M. Howard Award.

For the J. Watts Stovall Award, I have three nominations, Dr. C. L. Sherman—if any of you gentlemen want a further history on these men, the Chairman of the Council has that—and Dr. David Bates and Dr. C. H. Jones are the three.

DR. McDEVITT: Is a motion in order?

SPEAKER HOUSTON: I would rather have a motion without a discussion.

DR. McDEVITT: I was going to move that we wouldn't give any of these awards at all. If I am out of order, just tell me and I will sit down. I kind of go along with Dr. Floyd from Lexington on this. I will make the motion, and you can rule on it. I will move that these awards will just be not given at this meeting.

SPEAKER HOUSTON: A duly qualified delegate has made a motion. Do I hear a second?

A VOICE: Seconded.

SPEAKER HOUSTON: Do I have discussion?

A VOICE: Gentlemen, as I understand, I may be wrong, I thought the objection to the award was to the E. M. Howard Award and the J. Watts Stovall, that the Distinguished Service Award was not objected to. That's the only thing I have to say.

SPEAKER HOUSTON: That can be taken

as part of the discussion. Is there any other discussion.

DR. SCOTT: I would like to ask for information as to the motion. Does it refer to all three awards?

SPEAKER HOUSTON: That is the way the Speaker understands it. Dr. McDevitt, would you come to the loudspeaker and make your motion again?

DR. McDEVITT: I thought my motion was clear. I think this body doesn't need to give these awards. Is Dr. Floyd here? Well, I can't elaborate on my motion. I move that we don't give any awards at all.

SPEAKER HOUSTON: The motion made is that we give no awards. Is there any further discussion?

DR. UNDERWOOD: For a point of clarification and information both, the award that is called the J. Watts Stovall Award is also the selection of the outstanding general practitioner of Kentucky, whose name is transmitted to the House of Delegates of the American Medical Association, who select the outstanding general practitioner for the United States each year. I believe that wasn't made clear, and in the granting of the Stovall Award, that is given to the man who is selected as the outstanding general practitioner for the year, and that name is submitted to the House of Delegates of the American Medical Association. It is a joint affair.

SPEAKER HOUSTON: Is there any other discussion? Gentlemen, I have a motion before the House to do away with the awarding of all awards. Be sure you understand it. If that's what you want, that's what we'll do. Do we have any other discussion?

DR. MILLER: I rise to a point of order. We are not yet ready for new business, and all of the rest of this business should be transacted before we become involved in an acrimonious debate about this matter.

SPEAKER HOUSTON: I believe the speaker is correct, that it would be an order of new business, and the Chair will have to rule that we will take it up under new business. I think to make it clear, I want to have the approval of the House on that action. The Speaker will rule that this is a motion which should be considered new business and will give a chance for this motion to be brought up at the end of new business. Of course, that will mean that we will elect the recipients of the awards for this year. If you gentlemen want to do away with awards at this time, you will have to defeat the ruling of the Chair. All of the House of Delegates who are in favor of the ruling of the Chair that the motion is out of order at this time will please stand.

Will you sit down, please? All of those who

are in favor of not allowing the Chair's decision to stand, please stand. Therefore the motion will be received again under new business if it is the will of the delegate to so present the motion. We will now return to the election of our awards for this year. You have voted on your ballot for the Distinguished Service Award. There were no nominations for the E. M. Howard Award. You now have before you the three names for the J. Watts Stovall Award, Dr. C. H. Jones, Dr. Bates, and Dr. C. L. Sherman. Will you please vote your preference under the third space on your ballot for the J. Watts Stovall recipient?

DR. ATKINSON: I want to rise to a point of order. I was under the understanding that the original award, the Distinguished Service Award, that whenever there was a nomination on that, even in 1949 or 1950 that that nomination, if not voted on, would continue to be on file, is that correct?

DR. LUKINS: That is correct.

DR. ATKINSON: Therefore, we must have more than two nominations because the Council is directed to bring three, and I know there were more than three on file with the Council over the period of years, and they have not brought three. So therefore, we are not ready to vote on that.

SPEAKER HOUSTON: I want to ask the secretary to explain if that is the requirement of the award?

DR. UNDERWOOD: I don't know.

SPEAKER HOUSTON: Can the secretary tell me how I can find out?

DR. ATKINSON: Dr. Lukins knows.

DR. UNDERWOOD: Well, we'd have to go back and look it up in the record, the only way I could tell.

SPEAKER HOUSTON: You gentlemen have the discussion and all the facts before you as far as the Speaker knows (laughter) and I judge that Dr. Atkinson is referring only to the Distinguished Service Award, is that right, Dr. Atkinson?

DR. ATKINSON: I don't know anything about the other two awards, but I do know a little bit about the Distinguished Service Award.

SPEAKER HOUSTON: I will ask you to please vote on the J. Watts Stovall Award on your ballot so we'll have that finished.

A VOICE: All I want to know is who these people are. Do you have some biography on them?

SPEAKER HOUSTON: We will ask the Chairman of the Council to give you the biography of these nominees.

DR. McDEVITT: My motion was that there would be no awards at all, and you were going to rule on that later on?

SPEAKER HOUSTON: I can't rule on it because your motion was out of order, Dr. McDevitt.

DR. SPARKS: For the J. Watts Stovall Award, your Council has been handed three names.

Dr. C. H. Jones was born on March 23, 1884, in Calloway County and received his medical training at the University of Louisville, graduating in 1912. He returned to rural Calloway County where he practiced his profession up until 1946 when he was forced to retire because of coronary occlusion.

Dr. Jones' outstanding contribution to rural medicine, his unselfish service to humanity and his inspiration to young men locating in Calloway County is the basis for this nomination. He exemplifies the family doctor who always placed service to his people above self and financial reward. During World War I he served in the U. S. Army and during World War II he carried on his practice even though he was physically unable in order that his rural people would have service. When the young men returned he retired to his county home at Lynn Grove, Kentucky, because of his cardiac insufficiency.

David Arthur Bates, Route 4, Box 356, Louisville, Kentucky.

Born July 1882, Buechel, Kentucky.

A country boy who taught in schools of Jefferson and Bullitt counties to finance his way through medical school. Attended University of Louisville and graduated in the class of 1908. After graduation he practiced in the mountains of West Virginia for a while. Returned to Louisville for series of operations on his jaw for injuries received when his horse fell down the mountain with him.

Dr. Bates lives within ten miles of Louisville, the metropolis of the state. His type of practice therefore is unique. He does modern up-to-date practice through the country. His practice covers an area of approximately 40 miles. Area includes parts of Jefferson, Bullitt, Hardin, Nelson, and Shelby counties. Attends a family in Charlestown, Indiana, also. He has some colored practice and their appreciation is typified by one colored woman who said, "I have never heard a colored person say a word against Dr. Bates. They are his friends."

One true to his profession. Is kind, considerate and understanding of the poor and underprivileged. His pay has consisted of farm produce, an exchange of services, etc., and in numerous cases, no charges have been made. Debts have not been pushed beyond, perhaps, a reminder.

Has done all types of practice and performed minor surgery. Most successful fields were pneumonia, typhoid fever and obstetrics. Has

been called into consultation often. Outstanding work done during flu of 1918.

Has always been a consistent member of his county and state society.

Dr. Bates does a wide obstetrical practice covering parts of 5 counties. He has now delivered more than 4500 babies. 85% of these have been done in the home. His technique compares favorably with that of a specialist in a modern hospital. He has never lost a woman in childbirth and has never had a case of Puerperal fever. A patient for whom he recently delivered her 14th child but for whom it was his first delivery told him, "You are the best doctor who ever sat on the foot of my bed."

Wonderful family man and is active in community affairs. He is a consistent church member. Schools have always been close to his heart. Helped organize Lovvorn School, Buechel, Kentucky, in 1917. He moved to Okolona, Ky.,—his present home—a neighboring community, in 1918. Was school trustee for years. Was instrumental in moving Okolona School from two-room building to larger school in 1924. Elected to Jefferson County School Board in 1936. Has been a member since. Acted as Chairman for 8 years and is now vice-chairman. In 1950, largely through Dr. Bates' efforts, a 1½ million dollar Southern High School built in Okolona. He presided at its dedication and the first school annual dedicated to him.

In 1947 an appreciation banquet given to him by the community and gifts presented to him.

His loyalty to the profession, his life of self sacrifice, his high standard of ethics, his moderate charges and his willingness to answer calls, regardless of the social or financial standing of the family, makes a professional life that is a bulwark against any form of government controlled medicine.

A letter to Dr. Underwood nominating Dr. Sherman states:

"From time to time I run into an announcement concerning the award for outstanding practitioner for the year; every time I see one I think of the finest gentleman and physician whom it has ever been my pleasure to know among the many practitioners I have met. I am speaking of Doctor C. L. Sherman of Millwood, Kentucky. Do you know him? If you don't, may I suggest you go by to see him, and propose him to the Kentucky State Medical Association as a nominee for the award.

"He was the perfect general practitioner in every way. Besides personal qualifications and attributes of the very highest order, he kept himself up-to-date, worked assiduously, never refused a call, and, at the same time, saw to it his patients paid him if they had the money.

I don't know about the group of physicians in eastern Kentucky, but I am sure all physicians within 150 miles of Leitchfield know him and love and revere him as I do."

SPEAKER HOUSTON: You now have the three nominations for the J. Watts Stovall Award. Allow me to remind you that these nominations were made with serious intent, and I feel it is the duty of the House to handle these matters in a serious fashion. We ask you to vote on the J. Watts Stovall Award, and then I will ask Dr. Underwood to make what explanation he can concerning the Distinguished Service Award. Dr. Underwood.

DR. UNDERWOOD: In order to find out the early history of the Distinguished Service Award, what the record says, we'd have to dig back into the records and that would take considerable time. We are not in any position to do that in the spur of the moment. We could send to the office and make a desperate search. We might be able to find them tonight if that is your wish. We might not be able to find them that quick. I can't tell you because I don't know. I can tell you the names that were nominated last year if you wanted to include those in the list. I can't help but express the personal word that it seems a little odd that once a fellow is nominated for an award that there is no way to get his name out of nomination except to elect him, but maybe there's a reason for it and I won't know unless I look at the records. The names last year were John W. Scott, Lexington, Carl Norfleet, Somerset, W. O. Johnson, Louisville, E. M. Howard, Harlan. Dr. Carl Norfleet was selected to receive the award last year, leaving the names as a carry-over of John W. Scott, Lexington, W. O. Johnson Louisville, E. M. Howard, Harlan.

SPEAKER HOUSTON: This is now a matter to be settled by the House of Delegates. We have tried to give you all the facts. You now have the two nominations from the Council that were nominations that were mailed in to the Council. Dr. Howard and Dr. O'Nan. It seems that there is somewhere in the archives the fact that the Council should have brought you three nominations. That they failed to do. There also seems to be somewhere in the archives that the name is supposed to lay over year after year. I now throw the matter to the House of Delegates and I will accept a motion which will be your will in this matter.

DR. SCOTT: Mr. Speaker, it seems to me that the House of Delegates as I remember it in many sessions of this body had been instructed to present three names. It certainly has not presented three names to this House of Delegates. It presented two names, and therefore it seems to me that not having complied with the rules of the House that the whole matter is null as to this year. To go back and

pick up somebody because he had been presented in another year does not fulfill the House of Delegates' requirements. It has not presented the names of these three other men who were defeated last year, and I don't see how under any construction of the rules one could justify the requirement that three names be presented. Only two names have been presented, and I submit that the requirement has not been fulfilled and therefore the matter is null and void as far as this session of the House of Delegates is concerned.

SPEAKER HOUSTON: Do you want that in the form of a motion, Dr. Scott?

DR. SCOTT: I do.

SPEAKER HOUSTON: Does that refer just to the Distinguished Service Award? We fell short of providing the House of Delegates with the three required nominations. Do I have a second to Dr. Scott's motion?

A. VOICE: Seconded.

SPEAKER HOUSTON: I have a second to his motion. Gentlemen, you are voting on the question of doing away for this year with the Distinguished Service Award because of the technicality of not receiving three nominations as required. All in favor stand, please—I am sorry, we are open for discussion.

DR. MILLER: Before you vote on that, I haven't been around quite as long as Dr. Atkinson and Dr. Scott, but is it the custom of voting on these awards at the first session of the House of Delegates or at this time in order to have an election in time for the annual dinner, inasmuch as the annual dinner will not take place until Thursday? We still have the second session on Wednesday when the officers are elected, and this could be well taken care of at that time.

SPEAKER HOUSTON: I am going to consider that as a discussion.

DR. UNDERWOOD: Mr. Speaker, as a point of information, I believe these names are to be presented at the public meeting tomorrow night.

SPEAKER HOUSTON: Do I have any other discussion on it?

DR. GRAY: Can nominations be made from the floor now, or do they have to come through the Council?

SPEAKER HOUSTON: I was asking someone to give me that solution to this problem, and the doctor gave me a different motion. Of course, it is a matter for the House of Delegates to settle. I think if you wish to go on for this year and give a Distinguished Service recipient, you will have to defeat Dr. Scott's motion. Do you have any other discussion? If it is the will of the House that we give this year a Distinguished Service Award, you should vote no to Dr. Scott's motion. If it is the will of the House that we do not give a Distinguish-

ed Service medal this year, you will vote yes on Dr. Scott's motion. Is that fully understood? Is there any other discussion? All in favor of Dr. Scott's motion that we will not give a Distinguished Service Award this year, please stand. All opposed to Dr. Scott's motion please stand.

All right, it is the will of the House that we shall give the Distinguished Service Award this year. Now I will take a motion as to how we are to solve this present dilemma.

DR. GRAY: Mr. Chairman, I move that nominations be made from the floor.

SPEAKER HOUSTON: I have a motion that nominations be made from the floor. Do I have a second?

A VOICE: Seconded.

SPEAKER HOUSTON: I have a second. All in favor say aye. All opposed no. Carried.

I will now accept nominations for the Distinguished Service Award to be used as nominations along with the names of Dr. E. M. Howard and Dr. Walter O'Nan.

DR. KEITH SMITH: A point of order. If the Council is to select these names, I would suggest that we have a quick meeting of the Council and let them submit the names.

DR. SPARKS: The Council has been guided in selecting these names and has presented to you all the names that have been presented to it by the members of the Association, and I see no reason why it would have to come through the Council.

DR. SMITH: My point of order is the fact that the Council has to submit the names.

SPEAKER HOUSTON: The Council failed their responsibility, and I now have a motion and second. Any more discussion on that motion and second?

DR. MILLER: Dr. Gray, will you accept this amendment, that this House of Delegates instruct the Council to accept this name and its nomination?

DR. GRAY: Yes sir.

SPEAKER HOUSTON: Do you accept that? Who seconded Dr. Gray's motion a minute ago? I know I had a second. Did you accept that?

A VOICE: I accepted it.

SPEAKER HOUSTON: The nomination that will now come from the floor will be acceptable to the Council and they will present the same as their official duty. I will now accept the nomination from the floor for the Distinguished Service Award.

DR. GRAY: Mr. Chairman, I will nominate Dr. John Scott of Lexington.

SPEAKER HOUSTON: Do I have a second for this nomination?

A VOICE: Seconded.

SPEAKER HOUSTON: Dr. Scott.

DR. SCOTT: I didn't rise to second the nomination, Mr. Speaker. I don't think you ought

to do this to me. I can speak with certainty about this matter of the Distinguished Service Award, because I was a member of the House of Delegates at the time it was instituted, and there is no question at all as to the articles of institution that the Council was instructed to present three names to the House of Delegates for this election. I was opposed to it from the outset. I am opposed to this thing of having to hang a tag on Tom, Dick, and Harry. I think that we have places on the program, scientific work, we have honors in electing men to different offices in the Association. It is an honor to be a Delegate to this Association, and why do we want to go and call somebody a distinguished practitioner of Kentucky and another the most distinguished general practitioner and another one something else? That is beyond me, and why this House should take up its time, busy men as we are, with the tremendous amount of problems that face us that are serious, and resolve ourselves into what has been shown tonight by what's come from this rostrum as an absurdity. Why we should spend our time to resolve ourselves as judges of a popularity contest—which is what it amounts to—is beyond me.

Of course, I am suffering from the terrible scars of my defeat last year when my good friend Carl Norfleet very properly won against me. I was surprised that I even came as close to him as I did, but, all scars and wounds, aside I don't think I should be scarred again tonight. One set of wounds is enough for me. (Laughter) I really think I ought to be allowed to at least let these year-old wounds heal before I have to be subjected to another set. (Applause.)

SPEAKER HOUSTON: I have a nomination and a second of Dr. Scott. Do I have other nominations?

DR. GUY AUD: I'd like to rise to a point of order. I would like to ask a question. How can the Council accept this unless it goes into session?

SPEAKER HOUSTON: The Council has been authorized by the House of Delegates, who I consider as the ruling body of this Association, and if they so will I as Speaker would have to so rule.

A VOICE: I move that the nominations cease.

SPEAKER HOUSTON: All in favor of the nomination say aye. Opposed no. Carried.

I now have three names, Dr. E. M. Howard, Dr. O'Nan and Dr. Scott of Lexington. Will the tellers please collect the ballots for these awards.

While the ballots are being counted, we will have the report of the Secretary and General Manager, and allow me to remind you that if there is any report that is given tonight that

you want to hear read completely you have the right to ask it. If any chairman of any committee wishes to read his report in full, he has that right, or he can summarize it as he sees fit. I want the members of this House to know this is their meeting.

You will now have the report of the Secretary and General Manager.

DR. UNDERWOOD: Mr. Speaker, members of the House of Delegates, you have each received a copy of the report from the Headquarters Office. We would like to make this additional report. We believe our Association is truly making rapid progress. We are beginning once again to be the leaders in the field of medicine which we should be. Our Association is advancing in its usefulness to both the medical profession and the public. Our Association is taking its place in the leading medical associations of this country. The more you know about what is being done by the Executive Committee, the Council, the standing committees, the special committees, the advisory committees, the officers, the Councilors, and all other groups of our Association the more you will be impressed with their work and the value of our Association. The less you know, the less you will understand or appreciate the hours of unselfish devotion which are being spent in service by physicians all over our state. Few, if any, of you can know the full extent of the work that is being done, but many of you have some idea of it, and to that extent you understand and appreciate it.

As of September 25th of this year, we had 1,826 active members of the Association. Of this number, 1,432 or 79 per cent were members of the American Medical Association. If the remaining 394 active members of our Association knew the full extent of service to the profession and to the public which is being rendered by the American Medical Association, most of them would let nothing prevent them from being members of the American Medical Association. There are approximately 524 physicians in our state who do not belong to their county medical societies. Some are ineligible for membership for a variety of reasons, but the majority are eligible and they would be members if they knew what our Association is doing for the profession and for the public.

A copy of the full report of the Secretary and General Manager, together with the statistical supplement and the report of the Editor of the Journal is in each envelope. Mr. Speaker, we in the Headquarters Office appreciate the privilege of serving a great profession and we respectfully submit these reports together with the supplemental remarks.

REPORT OF THE SECRETARY AND GENERAL MANAGER TO THE 1952 SESSION OF HOUSE OF DELEGATES

In looking back over the great amount of progress the Association has made since the Centennial Meeting, we can all take great pride in the advances we have made the first year as we begin our second one-hundred years of service to the people of Kentucky. It has been twelve months of gratifying accomplishments, as the various officers, agencies and committees of the Association have moved ahead on so many fronts. The matter of writing the annual report of the Secretary and General Manager, for the entire Headquarters Staff therefore, is not a task, but a pleasure.

As our Association advances in usefulness to the medical profession and the public and seeks its place among the leading State Medical Associations of the country, it is well for all of us to remember in this stage of our growth, we are passing through a sort of "blue-printing stage" in many of our activities and programs. The proper foundation must be laid, just as in the construction of a large building. In much of the splendid work that is being done right now, the results will not be visible for months ahead, and the full impact on the profession may not be felt for a year or so, and for many years on the public.

If there are any delegates who doubt any part of the above statement, we believe that after a careful review of the multitude of reports in the envelope you have been given, your apprehensions will be dissipated immediately. And, as you read those reports, I feel that you will react as I have, along with others, that you cannot help but be impressed with the splendid leadership our President, Council, Executive Committee and other committees have provided and the tremendous amount of effort that has been expended in the past year.

As the work of the Association grew and expanded, necessitating more thought and the making of an increased number of decisions at the policy making level, the House of Delegates at the 1951 session accepted a recommendation that the Executive Committee of the Council be increased in number and machinery provided for its operation. The Executive Committee, while very conservative in its operation, has removed a considerable volume of the work from the shoulders of the Council, leaving the latter more time to devote to the more weighty matters. When it is remembered that the Executive Committee has met seven times, and the Council four times during the past twelve months, we are sure the membership will appreciate all the more the unselfish service, and the great amount of time

and effort its members are putting forth in your behalf as a member of the profession.

Although the military is making heavy demands on the medical profession for physicians to serve in the armed forces, the Association now has a total of 1803 as of September 1, 1952, as compared with a total of 1882 in 1951 and 1930 in 1950. The number of K.S.M.A. members paying 1952 A.M.A. dues is 1411 as of September 1, 1952, as compared with a total of 1351 in 1951 and 1412 in 1950. We have this year 60 members emeritus, 6 associate members and 129 student members. Although the annual dues of the Association were raised at the 1951 meeting, dues in 1952 were paid more promptly than in 1951. We in the Headquarters Office want to thank the County Medical Society Secretaries for their cooperation.

Growth of the Kentucky Physicians Mutual, Inc., continues at a satisfactory pace. Mr. Raymond F. Dixon serves as the Secretary to that organization. He reports that the number of counties now having participating agreements is 107 as compared to 104 in 1951. Mr. Dixon arranges for the meetings of the Board, keeps its minutes and looks after the heavy correspondence. The Headquarters Office is responsible for this agency of the Association. At present, the Physicians Mutual is working with the Blue Cross people in broadening the coverage offered to its policyholders, of which there are now approximately 135,472 as compared to 87,144 in 1951 at this time. The Kentucky Physicians Mutual is carefully directed by 22 Members of the Association who have shown a great capacity for good business judgment.

Mr. Dixon is also responsible for the activities in connection with the Rural Kentucky Medical Scholarship Fund. While some of the beneficiaries of the Fund are now serving in the military or will be called to serve immediately upon the completion of their postgraduate training, the influence of this worthy effort is making itself felt in a most satisfactory way in the rural sections of the state. The Fund has helped so many, Mr. Dixon reports, and has loaned about the maximum amount of money it can and continue to meet its commitments, that until re-payments are received, it cannot assist as many new students each year as it has been supporting in the past. Since the Fund was organized, it has helped or is helping a total of 69 doctors and medical students. The Board of physicians and laymen that administer to this Fund can well be proud of their work.

Several new programs were introduced this past year by the Association. All seemed to enjoy more than expected success. Included in this list was the Diabetic Detection Campaign, the Telephone Seminars and the Rural Health

Council. While the reports of committees responsible for these activities will be found in detail elsewhere in your envelope, we want to commend the splendid efforts of these committees to you and say that the Headquarters Office is glad to have had a part in the promotion of these programs, with Mr. Raymond Jones and Mr. J. P. Sanford cooperating. While these programs performed a very valuable service, it is felt in the years ahead they will grow into an even more substantial part of our effort.

For the first time that most of us now active in professional affairs can remember, the weight of the medical profession was felt for the benefit of the people in the General Assembly at Frankfort. At the 1952 session, a number of proposals drawn up in the public interest, sponsored by the State Board of Health and wonderfully supported by K.S.M.A., were enacted. Chief among these were the Hospital Licensure Bill and the revised Medical Practice Act. The excellent service rendered by the profession in this time-consuming and important work was directed by the Legislative Committee of the Association. Too much cannot be said for the Chairman, Co-Chairman, the members of the Committee, Officers of the Association, Councilors and cooperating members in the successful up-hill effort. In addition, Mr. Jones did a fine piece of work, along with Vincent Goodlett, the Association's attorney, both of them giving practically all of their time during the session to legislative matters.

Although the County Society Officers Conference was plagued by bad weather, the attendance was as good as it was the year before, and those who attended praised it highly. An unusually strong program, approved by the Executive Committee, was accepted as being most helpful by those who attended. Nationally recognized speakers included Louis H. Bauer, M. D., then President-Elect of the A.M.A., John T. T. Hundley, M. D., President of the Medical Society of Virginia, and Miss Charlotte Rickman of the North Carolina State Medical Association. An equally strong program is being planned for the 1953 meeting, scheduled for March 5. County officers who attended the 1952 session were polled after the meeting by Mr. Sanford, who cooperated in the arrangements, and the 1953 program will be built around the preferences expressed in the poll.

The Headquarters Office has sought to increase and improve informational service to both the profession and the public. Mr. Sanford cooperates in the writing of the Secretary's Letter, and he writes the Newsletter of the Education Campaign Committee, news releases for the newspapers and radio stations

of the state on all major activities of the Association, other promotional material used by the various agencies and committees of the Association. He arranged for television, radio and news coverage of the Rural Health Conference, and if present plans materialize, the television and radio coverage of this Annual Meeting will be the best we have ever had. Both local television stations have been very generous in the amount of public service time they have promised the Association, as have the radio stations. Both newspapers were contacted early and have shown a keen interest in the program that has been scheduled and those guest speakers who are participating.

Based on what is known of the plans for this meeting, the carefully made preparations of all the committees charged with the responsibility of promoting it, we believe all will agree when it is over that it will be the best routine annual meeting we have ever had, and that in many respects it will rival the Centennial Meeting. It was decided by the Committee on Scientific Assembly and the Committee on Arrangements, that special emphasis will be given to a matter that should compel the interest of all thinking people: Civil Defense and the treatment of Atomic Illness.

To Mr. Sanford has fallen the responsibility of implementing the policies of these committees and carrying out their directives. It is the goal of this Association to have one of the outstanding meetings of the smaller associations, and your constructive criticisms are welcomed.

It is, of course, not feasible for the Secretary in this report to comment on the work of all our fine committees. However, it is difficult to refrain from taking note of the excellent work that is being done by the Diabetes Committee, the Education Campaign Committee, the Committee on Emergency Medical Service, the K.S.M.A. Dental Committee, the Committee on Medical Practice, the Committee on Medical Service, the Committee on Rural Health and the Committee on the United Mine Workers Welfare and Retirement Fund.

While the Kentucky Advisory Committee to Selective Service is not a true Association committee, since it is appointed by the National Advisory Committee to Selective Service, six of our members devote a great amount of effort to this necessary and difficult work. The Headquarters Office handles the heavy and tedious correspondence for this committee, under the direction of A. Clayton McCarty, M. D., Committee Chairman. The work of this committee in the past months has been unusually heavy.

It is the pleasure and function of the Headquarters Staff to work with all committees and assist in every possible way. The staff also

promotes the meetings of the Councilor Districts. Mr. Sanford has, since the first of the year, attended 64 committee meetings that took 202 hours of his time. The amount of time in promoting the work of the committees by the staff has not been estimated, but much of the work reported by committees in your envelopes reflects the efforts of the staff.

The House of Delegates of this Association should be complimented on the calibre of men it elects to the presidency of the Association. During the past year members, who have had an opportunity to observe, have been amazed at the great amount of time, effort, interest and seasoned and sagacious leadership your 1952 President has brought to the Association. There is every reason to believe the 1953 President will be equally effective in his leadership.

We regret the resignation of Mr. Jones as Field Secretary. We are grateful for his loyal and devoted efforts to the Association.

Mr. Sanford has asked me to express to you his sincere and deep appreciation for the co-operation and support that the Officers, Councilors and Committees of the Association have extended to him during the past year.

Respectfully submitted,

/s/ Bruce Underwood

Bruce Underwood, Louisville

Secretary and General Manager

REPORT OF THE EDITOR TO THE

1952 SESSION OF HOUSE OF DELEGATES

During the period covered in this report, which includes the issues of the Journal from July 1951 to June 1952, few changes have been made in the format of the Journal although there has been continuous effort to improve the content.

All scientific articles printed have been reviewed for technical accuracy by a Consultant on Scientific Articles and recommended as being worthy of publication in our Journal.

A total of 63 articles were published in the twelve issues. Fifty-two were scientific articles, which occupied 254 pages, and eleven were special articles, requiring 41 pages. A total of 36 editorials were written which, including the masthead, occupied 35 pages. A total of 334 pages were devoted to other printed matter, which included the Organization Section, President's Page, County Society Reports, Pertinent Paragraphs, News Items, In Memoriam, Book Reviews, other organizational material such as the proceedings of the 1951 House of Delegates (which occupied the entire December issue), Constitution and By-Laws, Blue Shield Schedule of Indemnities, the front cover index, and other miscellaneous items. All

reading matter as broken down above totaled 664 pages which, together with 386 advertising pages, made a total of 1,050 pages in the twelve issues. There was a ratio of 1.7 pages of reading matter to each page of advertising.

During the twelve month period a total of 30,550 copies were printed at a cost of \$15,114.11. The copies were distributed to the membership, to other paid subscribers, to the many other Journals with whom we exchange, to our advertisers, and to some libraries and persons who receive complimentary copies. A few single issues are sold and some are filed in the archives of the Association.

Total receipts, principally from advertising, were \$12,992.96, leaving a deficit to be paid from dues of \$2,111.15. On the basis of costs per member, the twelve issues forwarded to each member cost \$8.39 of which \$7.22 was recovered from advertising and the remaining \$1.17 was paid from dues.

The actual costs are considerably higher since these figures do not include the salaries of the headquarters staff for the portion of their time spent on Journal activities. The

costs included are: printing, \$12,997.50; cuts, \$787.54; mailing, \$564.11; telephone, telegraph and express, \$122.01; and proofreading of scientific articles and travel, \$642.95. It may be seen that the publication of our Journal is a sizeable and an expensive undertaking. Fortunately, our advertisers permit our members to get a "bargain" in our Journal since each member receives a copy monthly which costs 70c to produce for only 10c of his dues.

We wish to express our appreciation to the Advisory Committee to the Editor whose advice and counsel have been invaluable; to the Consultants on Scientific Articles who are of great assistance in maintaining a high standard of scientific content; to the authors of scientific articles for their excellent papers; and to Mr. R. F. Dixon and Mr. J. P. Sanford, who are largely responsible for the Journal, and to the other members of the headquarters staff who contribute to the publication of the Journal.

Respectfully submitted,
/s/ Bruce Underwood
Bruce Underwood, Louisville
Editor

MEMBERSHIP REPORT

(Report of Membership of the Kentucky State Medical Association as of September 25, 1952. This report does not include physicians who are ineligible for membership.)

County	Councilor District	Non- Mbrs.	Active Mbrs.	Emeritus Mbrs.	Assoc. Mbrs.	Service Mbrs.	A.M.A. Mbrs.
Adair	6	0	6	0	0	0	6
Allen	6	0	5	0	0	0	5
Anderson	7	2	2	0	0	0	1
Ballard	1	6	0	0	0	0	0
Barren	6	2	24	1	0	0	21
Bath	9	0	4	0	0	0	3
Bell	15	8	24	0	0	0	19
Boone	8	3	4	0	0	0	3
Bourbon	9	2	14	0	0	0	1
Boyd	13	7	39	0	0	0	28
Boyle	12	6	18	0	0	0	12
Bracken	9	5	3	0	0	0	2
Breathitt	14	1	4	0	0	0	3
Breckinridge	4	0	4	0	0	0	4
Bullitt	4	0	0	0	0	0	0
Butler	6	0	2	0	0	0	2
Caldwell	3	2	8	0	0	0	3
Calloway	1	1	15	0	0	0	13
Campbell-Kenton	8	42	109	0	0	0	98
Carlisle	1	0	5	0	0	0	1
Carroll	7	0	6	1	0	0	6
Carter	13	4	7	0	0	0	7
Casey	12	1	5	0	0	0	5
Christian	3	14	27	0	0	0	23
Clark	11	4	11	0	0	0	8
Clay	15	3	2	0	0	0	2
Clinton	12	0	4	0	0	0	3
Crittenden	3	0	3	0	0	0	2
Cumberland	6	0	5	0	0	0	3
Daviess	2	6	50	1	0	0	42

County	Councillor District	Non- Mbrs.	Active Mbrs.	Emeritus Mbrs.	Assoc. Mbrs.	Service Mbrs.	A.M.A. Mbrs.
Edmonson	6	0	2	0	0	0	2
Elliott	13	1	0	0	0	0	0
Estill	11	0	7	0	0	0	0
Fayette	10	34	168	2	0	0	119
Fleming	9	2	6	1	0	0	2
Floyd	14	15	16	0	0	0	11
Franklin	7	1	17	0	0	0	14
Fulton	1	1	10	0	0	0	10
Gallatin	7	0	1	0	0	0	1
Garrard	12	1	6	0	0	0	6
Grant	7	1	6	0	0	0	1
Graves	1	1	17	0	0	0	16
Grayson	4	2	7	0	0	0	6
Green	4	1	3	1	0	0	2
Greenup	13	2	6	0	0	0	4
Hancock	2	1	0	0	0	0	0
Hardin	4	1	18	0	0	0	9
Harian	15	14	39	0	0	2	39
Harrison	9	2	9	0	0	0	2
Hart	4	1	6	0	0	0	6
Henderson	2	2	20	0	0	0	15
Henry	7	2	7	0	0	0	6
Hickman	1	1	2	0	0	0	2
Hopkins	3	2	22	0	1	1	14
Jackson	11	1	2	0	0	0	2
Jefferson	5	180	571	42	5	0	478
Jessamine	10	1	6	0	0	0	2
Johnson	14	1	8	2	0	2	8
Knott	14	1	2	0	0	0	2
Knox	15	0	8	1	0	0	5
Larue	4	0	4	0	0	0	2
Laurel	15	1	11	0	0	0	10
Lawrence	13	3	6	0	0	0	5
Lee	11	3	1	0	0	0	0
Leslie	15	4	0	0	0	0	0
Letcher	14	7	10	0	0	0	5
Lewis	13	1	4	0	0	0	3
Lincoln	12	0	6	1	0	0	6
Livingston	1	3	3	0	0	0	1
Logan	6	2	8	0	0	0	8
Lyon	3	1	5	0	0	0	2
McCracken	1	8	39	1	0	1	37
McCreary	12	0	4	0	0	0	4
McLean	2	1	5	0	0	0	0
Madison	11	2	27	0	0	0	23
Magoffin	14	3	1	0	0	0	1
Marion	4	3	7	0	0	0	7
Marshall	1	2	4	0	0	0	3
Martin	14	2	1	0	0	0	0
Mason	9	3	13	0	0	0	5
Meade	4	3	2	0	0	0	1
Menifee	11	0	1	0	0	0	1
Mercer	12	3	11	0	0	0	9
Metcalfe	6	0	4	0	0	0	2
Monroe	6	3	3	0	0	0	3
Montgomery	11	5	7	0	0	0	6
Morgan	13	3	2	0	0	0	2
Muhlenberg	3	0	10	0	0	0	10
Nelson	4	1	10	0	0	0	7

County	Councilor District	Non-Mbrs	Active Mbrs.	Emeritus Mbrs	Assoc-Mbrs.	Service Mbrs.	A.M.A. Mbrs.
Nicholas	9	2	3	0	0	0	0
Ohio	2	3	3	0	0	0	0
Oldham	7	0	5	0	0	0	4
Owen	7	1	4	0	0	0	3
Owsley	11	1	3	0	0	0	3
Pendleton	9	1	6	0	0	0	1
Perry	14	2	26	0	0	0	22
Pike	14	13	23	0	0	0	22
Powell	11	2	0	0	0	0	0
Pulaski	12	6	20	0	0	0	20
Robertson	9	0	1	0	0	0	0
Rockcastle	12	0	5	0	0	0	1
Rowan	13	0	5	0	0	0	3
Russell	12	6	0	0	0	0	0
Scott	9	1	11	1	0	0	1
Shelby	7	0	7	0	0	0	7
Simpson	6	4	4	0	0	0	0
Spencer	4	3	1	0	0	0	1
Taylor	4	2	8	1	0	0	7
Todd	3	0	5	0	0	0	5
Trigg	3	0	4	0	0	0	4
Trimble	7	0	1	0	0	0	1
Union	2	2	9	0	0	0	7
Warren	6	5	27	2	0	0	26
Washington	4	0	3	0	0	0	3
Wayne	12	1	5	0	0	0	2
Webster	2	6	5	0	0	0	5
Whitley	15	4	15	0	0	0	11
Wolfe	11	1	1	0	0	0	0
Woodford	10	2	5	2	0	0	0
		524	1826	60	6	6	1432

SPEAKER HOUSTON: The Speaker refers report of the Secretary and General Manager to Reference Committee No. 1. We will now have the report of the Treasurer, Dr. Troutman of Louisville.

DR. TROUTMAN: Mr. Speaker, you have the recent audit of the financial condition of this Association on file. We submit it for your approval.

REPORT OF THE TREASURER TO THE 1952 SESSION OF HOUSE OF DELEGATES

We wish to refer you to the recent Audit of our financial situation for the past year.

Your Treasurer finds himself in agreement with this Audit.

Respectfully submitted,
/s/ Woodford B. Troutman,
Woodford B. Troutman, Louisville
Treasurer

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August 6, 1952

REPORT OF AUDIT

We submit herewith report of our audit of the books and records of your Secretary, Dr. Bruce Underwood, and your Treasurer, Dr. Woodford B. Troutman, for the fiscal year ending June 30, 1952.

The Association revised its accounting system during the year and also, for the first

time, operated on a budget approved by the Council. A comparison of the actual income and expenses for the fiscal year with the budget indicated that the budget had been carefully prepared. The only major variation was an under-estimate of income from membership dues. The budget for the fiscal year 1951-52 was approved in May, 1951. During the fiscal year the House of Delegates voted to increase the dues, effective January 1, 1952.

The assets and liabilities were verified in the manner and to the extent stated in the schedules and comments in this report. Income and expenses were checked by us to the extent deemed necessary to satisfy ourselves as to

the accuracy and integrity of the records.

We hereby certify that, in our opinion, the attached Statement of Financial Condition as of June 30, 1952 and the Statement of Income and Expenses fairly present the financial condition of the Kentucky State Medical Association and the results of its operations for the year ending that date.

Respectfully submitted,

(Signed)

Christen, Brown, McCroskey and
Rufer, Certified Public Account-
ants

STATEMENT OF FINANCIAL CONDITION

June 30, 1952

ASSETS

Current Assets:

Cash in Banks	\$24,747.84	
Petty Cash Fund	15.34	\$ 24,763.18
		<hr/>
Accounts Receivable—Advertising		1,135.87

Investments:

U. S. Government Bonds—At Cost.....	31,481.00	
Louisville Title Mortgage Stock—At Cost.....	755.52	32,236.52
		<hr/>

TOTAL CURRENT ASSETS		58,135.57
----------------------------	--	-----------

Library	490.00	
Office Equipment—At Cost	\$5,423.78	
Less Reserve for Depreciation	965.82	4,457.96
		<hr/>

McDowell Property—At Appraised Value.....	25,000.00	
McDowell Home—Furnishings at Appraised Value.....	5,000.00	30,000.00
		<hr/>

TOTAL ASSETS		\$ 93,083.53
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LIABILITIES, DEFERRED INCOME AND NET WORTH

Accrued Pay Roll Taxes		\$ 447.47
McDowell Fund—Unexpended Balances of Funds for Designated Purposes		1,424.70

Deferred Income:

Advance Collections on Exhibits Space, Less Expenses		4,300.06
Surplus		56,911.30
Surplus—Appraisal McDowell Property		30,000.00
		<hr/>

TOTAL LIABILITIES, DEFERRED INCOME AND NET WORTH		\$ 93,083.53
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STATEMENT OF INCOME AND EXPENSES
FISCAL YEAR ENDING JUNE 30, 1952

3

	ACTUAL		BUDGET	
<u>Current Fund - (Schedule A)</u>				
Income	\$47,048.00		\$50,000.00	
Expenses	43,450.91		40,605.00	
Excess Income Over Expenses		\$ 4,191.73		\$ (13,705.00)
<u>Journal of the Kentucky State Medical Association - (Schedule B)</u>				
Income	12,932.96		14,150.00	
Expenses	14,899.07		15,010.00	
Excess Expenses Over Income		(1,906.91)		(960.00)
<u>Annual (Centennial) Meeting - (Schedule C)</u>				
Income	4,967.50		6,000.00	
Expenses	15,031.47		15,000.00	
Excess Expenses Over Income		(10,063.97)		(6,032.50)
<u>Post Graduate Education</u>				
Income	923.50			
Expenses	1,130.62		1,000.00	
Excess Expenses Over Income		(215.12)		(1,000.00)
Totals		(7,944.27)		(11,705.00)
<u>Other Expenses</u>				
Officers, Delegates, Councilors and Miscellaneous				
Committees Expense	3,550.06		2,500.00	
Educational Campaign Committee Expense	2,173.63		2,000.00	
Woman's Auxiliary	156.76		1,000.00	
Annual County Society Officers' Conference Expenses	102.05		400.00	
Rural Health Conference Expenses	105.00	5,423.00	250.00	
EXCESS EXPENSES OVER INCOME		\$ (13,423.27)		\$ (27,190.00)

STATE OF INCOME AND EXPENSES (Continued)
SCHEDULE A - INCOME AND EXPENSES - CURRENT FUND

4

	ACTUAL	BUDGET		
		Budget Allowance	Over Actual	Under Actual
<u>Income</u>				
Membership Dues (Schedule A-1)	\$ 44,974.00	\$ 29,900.00		\$ 15,074.00-A
<u>Services:</u>				
Kentucky Physicians' Mutual, Inc.	825.00	900.00	\$ 75.00	
Rural Kentucky Medical Scholarship Fund	275.00	800.00	325.00	
American Medical Association - Fees for Dues Collections	370.74	300.00		70.74
Kentucky Medical Advisory Committee	(62.54)	-0-		(62.54)
Interest and Dividends on Investments	1,120.49	900.00		
Miscellaneous Income	140.00	300.00	154.00	220.46
Total Income	47,648.66	32,900.00	554.00	15,302.60
<u>Expenses:</u>				
<u>Salaries:</u>				
Executive	\$12,279.99			
Field Secretary	4,125.00			
Office Salaries	11,016.80			
Travelling Expenses, Headquarters Staff	27,421.59	29,700.00	2,338.41	
Rent	1,100.85	3,160.00	2,019.35	
Printing	2,400.00	2,400.00		
Postage and Stationery	561.17	2,000.00	1,438.83	
Office Supplies	2,708.02	3,000.00	791.98	
Repairs to Office Equipment	561.55	200.00		361.55
Telephone, Telegraph and Express	72.95	75.00	2.05	
Insurance	723.00	550.00		179.00
Auditing	32.04	140.00	107.96	
Pay Roll Taxes	187.50	200.00	32.50	
Miscellaneous Services	366.49	400.00	13.51	
Membership Cards	1,227.25	900.00		327.25
Miscellaneous Expense	41.00			
Hospitalization Insurance	193.42			
General Taxes	13.00			
Legal Services	15.99			
Pay Roll Taxes - Current	1,000.00-B			
Attorney's Traveling Expense	170.97-C			
McDowell Fund Appropriation	1,764.25-C			
Reimbursement of Expenses by Kentucky Medical Advisory Committee	118.95-B			
Depreciation	1,500.00			
Public Relations Councilors - Services	(1,500.00)			
Veterans' Fees Schedules	490.84			
Physicians' Directories	2,700.00-B	6,528.42	3,000.00	3,528.42
Total Expenses	43,456.93	46,605.00	7,544.29	4,396.22
Excess Income Over Expenses	\$ 4,191.73	\$ (13,705.00)	6,992.29	\$ 10,906.44
			10,906.44	
			217,696.73	

A - Dues increased after budget was approved
 B - Expenditure authorized after budget was approved
 C - Unbudgeted expense

STATEMENT OF INCOME AND EXPENSES - (Continued)

5

SCHEDULE B - INCOME AND EXPENSES - JOURNAL OF THE KENTUCKY STATE MEDICAL ASSOCIATION:

	ACTUAL		BUDGET		
			Budget Allowance	Over Actual	Under Actual
<u>Income:</u>					
American Medical Association Agency Advertising	\$ 11,230.25				
Local Advertising	1,537.21				
Journal Sales and Subscriptions	225.50				
Total Income		\$ 12,992.96	\$ 14,150.00	\$ 1,157.04	
<u>Expenses:</u>					
Printing	11,667.50	12,000.00		132.50	
Color Advertising, Copper Halftones, etc.	1,983.81	1,700.00			\$ 283.81
Postage	200.00	300.00		100.00	
Express	79.56	60.00			19.56
Envelopes	-0-	200.00		200.00	
Telephone and Telegraph	42.45	50.00		7.55	
Salaries	600.00	600.00			
Sundry Expense - Associate Editor	42.95	100.00		57.05	
Uncollectible Advertising Accounts	57.90	-0-			57.90
Discounts and Allowances	25.70	-0-			25.70
Total Expenses		14,869.87	15,010.00	497.10	369.97
Excess Expenses Over Income		\$ (1,906.91)	\$ (660.00)	659.94	\$ 306.97
\$ 1,046.91					

STATEMENT OF INCOME AND EXPENSES - (Continued)

6

SCHEDULE C - INCOME AND EXPENSES - ANNUAL (CENTENNIAL) MEETING

	ACTUAL		BUDGET		
			Budget Allowance	Over Actual	Under Actual
<u>Income</u>					
Annual Meeting - Exhibitors' Space - Centennial Volume	\$ 4,092.50				
	875.00				
Total Income		\$ 4,967.50	\$ 8,000.00	\$ 3,032.50-A	
<u>Expenses</u>					
<u>Centennial Meeting Expenses:</u>					
Scientific and Historical Exhibits	4,346.70				
Guest Speakers	2,032.00				
Centennial Section - Courier-Journal Volume Expenses	693.10				
	2,952.95				
Total	10,024.75				
<u>Annual Meeting Expenses:</u>					
Exhibits Expense	1,911.00				
Rent - Columbus Auditorium	600.00				
Programs and Leaflets	795.35				
Subscription Dinner and President's Luncheon	524.10				
Transcript of Proceedings	252.60				
Honorariums and Clerical	503.17				
Printing	125.34				
Public Address System	50.00				
Radio	14.95				
Pictures and Slides	107.11				
Miscellaneous	60.00				
Total	5,000.69				
Total Expenses		15,031.47	15,000.00		\$ 31.47
Excess Expenses Over Income		\$ (10,063.97)	\$ 6,032.50	\$ 3,032.50	\$ 31.47
\$ 2,962.50					

A - Excess budgeted income resulted because advance collections on 1952 exhibit space was considered income for the fiscal year ending June 30, 1952, as was the previous practice. Under present accounting the payments on June 30, 1952, and those received subsequent thereto, will be considered as income from the annual meeting during the fiscal year ending June 30, 1953.

STATEMENT OF INCOME AND EXPENSES

SCHEDULE A-1—Association Dues:

	Membership				
	1951	1952	Rate	Amount	
Regular Members:					
Current Year Dues		1,753	\$25.00	\$43,825.00	
Current Year Dues		3	12.50	37.50	
Current Year Dues		12	5.00	60.00	
(Associates)	40		5.00	25.00	\$43,947.50
<hr/>					
1951 Dues Paid in 1952.....	40		15.00	600.00	
1951 Dues Paid in 1952.....	1		12.50	12.50	
1951 Dues Paid in 1952.....	30		7.50	225.00	
1951 Dues Paid in 1952.....	12		5.00	60.00	897.50
<hr/>					
Total Regular Membership...	83	1,773			44,845.00
Student Members	125	4	1.00		129.00
<hr/>					
TOTALS	208	1,777			\$44,974.00

American Medical Association dues of your members, collected for the account of that Association, amounted to \$36,212.50, and were remitted to its Treasurer during the year under review.

CASH:

Checking Accounts:

	Balance Per Bank	Less Out- standing Checks	Balance Per Books
Checking Accounts:			
Bullitt County, Bank, Shepherdsville, Ky.			
Treasurer's Account	\$ 9,942.82	\$ 7,561.24	\$ 2,381.58
Lincoln Bank & Trust Co.			
Association Account	647.50	647.50	0
Lincoln Bank & Trust Co.			
Journal Account	1,730.42	1,730.42	0
Lincoln Bank & Trust Co.			
Meeting Account	290.00	290.00	0
Lincoln Bank & Trust Co.			
McDowell Fund	232.58	232.58	0
Farmers National Bank, Danville, Ky.			
McDowell Fund—Petty Cash Fund	41.66	27.48	14.18
TOTALS	\$12,884.98	\$10,489.22	\$ 2,395.76
Savings Accounts:			
Bullitt County Bank, Shepherdsville, Ky.			
Treasurer's Account	4,328.71		4,328.71
Lincoln Bank & Trust Co.	9,511.68		9,511.68
First National Bank	10,511.69	2,000.00	8,511.69
TOTALS	\$37,237.06	\$12,489.22	\$24,747.84
Petty Cash Fund			15.34
TOTAL CASH			\$24,763.18

Cash in Banks subject to check was reconciled with the balances reported to us by the Banks. Cash in savings accounts was verified by correspondence with the Banks.

Petty cash fund was counted by us on July 21, 1952.

ACCOUNTS RECEIVABLE—ADVERTISING:

Journal Advertising Bureau			\$1,050.54
Other Advertising Accounts:			
Eline Realty Company		\$23.45	
J. W. Fitzpatrick, M. D.		5.00	
Norton Memorial Infirmary		36.38	
Frank Pirkey, M. D.		25.50	
		<hr/>	
Total		\$90.33	
Less Advertising Paid in Advance:			
A. H. Danks	\$2.50		
George White	2.50	5.00	85.33
	<hr/>	<hr/>	
TOTALS			\$1,135.87

The Journal Advertising Bureau account represents the amount due for advertising in June in the Journal of the Kentucky State Medical Association. This account was paid on July 12, 1952.

Other advertising accounts are for monthly advertising in the Journal.

Uncollectible accounts totaling \$57.90 were written off during the year.

INVESTMENTS:

	Maturity Value	Present Redemption or Market Value	Cost
U. S. Savings Bonds, Series F.....	\$ 650.00	\$ 571.50	\$ 481.00
U. S. Savings Bonds, Series G.....	31,000.00	29,660.00	31,000.00
	<hr/>	<hr/>	<hr/>
TOTALS	\$31,650.00	\$30,231.50	\$31,481.00
82 Shares Louisville Title Mortgage Co., Common Stock.....		1,148.00	755.52
		<hr/>	<hr/>
TOTALS		\$31,379.50	\$2,236.52

The above investments are stated at cost.

These investments are held on safekeeping with the Bullitt County Bank, Shepherdsville, Ky., and were verified by correspondence with that bank.

Interest received on bonds amounted to \$1,025.00 and dividends on stock were \$57.40.

LIBRARY AND OFFICE EQUIPMENT:

	Cost	Reserve for Depreciation	Depreciated Value
Library:			
49 Bound Volumes Journal of the State Medical Association	\$ 490.00		\$ 490.00
Office Equipment	5,423.78	965.82	4,457.96
	<hr/>	<hr/>	<hr/>
TOTALS	\$ 5,913.78	\$965.82	\$4,947.96

Office equipment purchases of \$515.37 during the year were verified with invoices. The Budget allowance for the year was \$500.00

Depreciation of \$490.84 was charged to expense during the year. No depreciation is taken on equipment in the year of purchase.

McDOWELL PROPERTY AND FURNISHINGS:

McDowell Property—At Appraised value.....	\$25,000.00
Furnishings - At Appraised value.....	5,000.00
	<hr/>

The Association reacquired the McDowell Property, Danville, Ky., from the Commonwealth of Kentucky, Division of State Parks, on June 6, 1949, at no cost. Before deeding it to the Commonwealth of Kentucky in 1935 for use as a State Park, the Association had purchased it for \$13,500.00. Other comments concerning this property were set forth in prior audit reports.

ACCRUED PAY ROLL TAXES:**Federal Unemployment Insurance Taxes—**

1950 - 51	\$276.50
Kentucky Unemployment Insurance.....	170.97
TOTAL	\$447.47

These taxes were computed by us and were verified with the returns filed.

McDOWELL FUNDS—UNEXPENDED BALANCES**OF FUNDS FOR DESIGNATED PURPOSES:****Furniture Account—Regular:**

Balance, June 30, 1951.....		\$1,105.55
Contributions	\$412.50	
Less Transfer to Repairs & Supplies Acct.....	(100.00)	312.50
TOTAL		1,418.05

Disbursements:

Furnishings for Home	910.50
----------------------------	--------

Balance, June 30, 1952	\$ 507.55
------------------------------	-----------

Furniture Account—Woman's Auxiliary to Jefferson County Medical Society:

Balance, June 30, 1951.....	115.25
Contribution - Jefferson County Woman's Auxiliary	500.00
TOTAL	615.25

DISBURSEMENTS:

Furnishings	98.00
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Balance, June 30, 1952	517.25
------------------------------	--------

Furniture Account—Doctor's Office:

Balance, June 30, 1951.....	502.50
-----------------------------	--------

Disbursements:

Furnishings	183.90
-------------------	--------

Balance, June 30, 1952.....	318.60
-----------------------------	--------

Repairs and Supplies Account:

Balance, June 30, 1951.....		33.05
Appropriation from Kentucky State Medical Association.....	1,500.00	
Admissions	120.00	
Transfer from Furniture Account.....	100.00	
Contributions	155.00	
Insurance Premium Refund	117.58	1,992.58
TOTAL		2,025.63

Disbursements:

Services—Hostess	650.00	
Repairs	570.27	
Supplies	279.82	
Utilities	181.22	
Telephone	21.25	
Insurance	17.75	
Traveling	138.20	
Petty Cash Transferred to Petty Cash Fund....	100.00	1,958.51

Bank Account \$ 67.12

Farmers National Bank—**Cash Account:**

Balance in Bank, June 30, 1951..... 5.58

Deposits:

Admissions	\$ 46.00	
Contributions	21.35	
Cash Transferred from Repairs and Supplies....	100.00	
Repairs Refund	1.20	168.55

TOTAL 174.13

Disbursements:

General Expense	62.92	
Supplies	27.48	
Utilities	14.73	
Repairs	23.57	
Furnishings	31.25	159.95

Balance, June 30, 1952..... 14.18

TOTAL McDOWELL FUNDS, JUNE 30, 1952... \$1,424.70

The above statement reflects the activities of the McDowell Fund during the current year under review.

This account represents excess of income received by the Association for the McDowell Fund over disbursements over a period of years. The income consists of contributions from individuals, appropriations from the Association and auxiliary organizations, admission fees to the McDowell Home, etc., which have been designated by the donors for disbursement for the benefit of the respective accounts shown in the statement.

The unexpended cash in these accounts is included in the Association bank accounts.

The McDowell Memorial Foundation, Inc., was incorporated in 1951. We were informed that the aforementioned \$1,424.70 will be remitted to it after proper authorization.

ADVANCE COLLECTIONS ON EXHIBITS**SPACE, LESS EXPENSES:**

Advance Collections from Exhibitors for
1952 Annual Meeting \$4,397.50

Expenses:

Badge Holders	\$ 69.03	
Publicity	15.25	
Telephone and Telegraph.....	13.16	97.44

TOTAL \$4,300.06

The above represents advance collections from exhibitors for space at the 1952 annual meeting. These payments and those received subsequent to June 30, 1952 will be considered as income from the annual meeting during the fiscal year ending June 30, 1953.

SURPLUS:

Balance, June 30, 1951.....	\$72,096.50
Less:	
Adjustment for McDowell Fund—	1,761.93
Unexpended Balances as of June 30, 1951.....	<hr/> 70,334.57

Excess of Expenses over Income—**Current Year:**

Current Fund	\$ 4,191.73	
Journal of the Kentucky State Medical Association	(1,906.91)	
Annual and Centennial Meeting.....	10,063.97	
Post Graduate Education	(215.12)	
	<hr/> (7,994.37)	
Other Expenses	5,429.00	(13,423.27)

BALANCE, JUNE 30, 1952..... \$56,911.30

SURPLUS—APPRAISAL McDOWELL PROPERTY — \$30,000.00:

Represents surplus from appraisal of the McDowell property. Comments with respect to the asset shown on the balance sheet are set forth elsewhere in this report.

INSURANCE COVERAGE**Building—McDowell House—West Side South Second Street, Danville, Ky.:**

Fire and Extended Coverage—80% Co-insurance..... \$25,000.00

Contents—McDowell House:

Fire and Extended Coverage..... 2,000.00
 Fine Arts Policy—Contents—125-27 South Second Street, Danville, Ky.... 14,525.00
 Contents—Crawford Room, 125-27 South Second Street, Danville, Ky.... 1,500.00

Office Furniture and Equipment—620 South Third Street, Louisville, Kentucky:

Fire and Lightning 4,000.00 || Open Stock Burglary | 1,000.00 |
| Fine Arts Policy—Portraits—620 South Third Street, Louisville, Kentucky.. | 2,341.00 |

The policies on the McDowell furnishings have been issued to the McDowell Memorial Foundation Inc., with the exception of policy on contents of the Crawford Room. The latter is issued to the Colonial Dames.

BLANKET POSITION BOND COVERAGE

All employees (excluding the President and three Vice Presidents)—Each \$10,000.00

This bond was inspected by us, and was further verified by correspondence with the local agent of the bonding company.

SPEAKER HOUSTON: The report has been received and referred to Reference Committee No. 1. We are ready for the reports of the Councils by district. The First District, Dr. Pace.

DR. PACE: Mr. Chairman, the report has been filed with the Secretary.

**REPORT OF FIRST COUNCILOR DISTRICT
TO THE
1952 SESSION OF HOUSE OF DELEGATES**

Many changes have occurred in our district during the last year. The full impact of the Atomic Energy Installation at Paducah has caused a near breakdown in almost every field of service other than medicine.

We have been able to care for all patients in this area who needed hospitalization by utilizing the full facilities of all of our hospitals. An adequate number of physicians have located in this area to fully meet the total needs of the people. Provisions are being made at present to complete the new Baptist Hospital at Paducah and within one year it will be ready for patients. An addition to Riverside Hospital at Paducah, adding thirty more beds is now in process of construction. It is believed that the combined additional beds offered by these new constructions will be sufficient to accommodate those needing hospitalization in this area at this time.

We have had three Councilor District meetings in the last year at Hickman, Murray and Paducah. All meetings were well attended. County society meetings have been well attended.

Jennie Stuart Memorial Hospital at Hopkinsville has a nurses training school operating in connection with Murray State College, now in its fourth year. It has good prospects of turning out a fair number of greatly needed nurses.

Real effort is being made to take care of public relations. Emergency call systems have been set up in the larger centers. The doctors are charitable and no known cases in need of attention fail to get it. There are no real complaints, ill-will or hostilities existing among the population of the Third District against the profession.

Respectfully submitted,
/s/ Delmas M. Clardy
Delmas M. Clardy, Hopkinsville
Councilor, Third District

SPEAKER HOUSTON: The report has been filed and referred to Reference Committee No. 1. The Fourth District, Dr. Greenwell.

DR. GREENWELL: The report has been filed.

REPORT OF THE FOURTH COUNCILOR DISTRICT TO THE

1952 SESSION OF HOUSE OF DELEGATES

The Fourth District has thirteen counties composed of: Nelson, Bullitt, Spencer, Washington, Marion, Larue, Green, Hart, Grayson, Hardin, Breckinridge, Meade and Taylor.

We have 87 physicians: 74 are members and 13 are non-members, at the date of this report. We have had 4 new members in the District since January of 1952.

Most of the counties hold regular monthly meetings, where they have enough members to meet. Those who do not have societies attend meetings of adjoining counties. The Muldraugh Hill Medical Society is situated in this District and meets four times a year. Most of their members attend these meetings regularly.

We have had four hospitals erected, or, are being erected, within the last three years.

My Councilor District held its regular meeting in Bardstown on July 30th and was well attended by members of this and adjoining districts. We were honored by having as our guests: President Clark Bailey, M. D. of Harlan, Kentucky and President-Elect R. Haynes Barr, M. D., of Owensboro, Kentucky.

Respectfully,
/s/ J. I. Greenwell
J. I. Greenwell, New Haven
Councilor, Fourth District

SPEAKER HOUSTON: That report is referred to Reference Committee No. 1.

The Fifth District, Dr. Slucher.

DR. SLUCHER: The report has been filed.

REPORT OF FIFTH COUNCILOR DISTRICT TO THE 1952 SESSION OF HOUSE OF DELEGATES

The Fifth District consists of Louisville and Jefferson County. There are 789 white physicians in this District, 610 of them being members of the County and State Societies, and 474 having paid A.M.A. dues.

Jefferson County holds a regular monthly meeting (except for July and August) with scientific papers by local and out of town speakers. All of the hospitals in Louisville have twelve compulsory staff meetings per year and many of the special societies have nine and ten compulsory meetings per year.

Inasmuch as the physicians in Louisville are constantly complaining of how many medical meetings they have to attend, it was deemed wise—again this year—not to have any special district meeting.

Respectfully submitted,
/s/ R. R. Slucher
R. R. Slucher, Buechel
Councilor, Fifth District

SPEAKER HOUSTON: The report has been filed and referred to Reference Committee No. 1. The Sixth District, Bowling Green.

DR. TOOMEY: The report has been filed.

REPORT OF SIXTH COUNCILOR DISTRICT TO THE

1952 SESSION OF HOUSE OF DELEGATES

There has been a great relief in the crowded conditions in the hospitals of this district during the past year. The opening of the hospitals in Russellville and Scottsville during the year have relieved the surrounding hospitals to a large extent. Sampson Hospital in Glasgow and the Bowling Green City Hospital have added new wings, that have relieved the crowded conditions to a great extent. It is my opinion that the people are well cared for, the physicians are doing an excellent job in caring for the indigent, and everyone is getting adequate treatment. Public health will be greatly benefited by the new health clinics now under construction at Glasgow and Bowling Green.

We have had a number of young physicians starting their practice within the district. Two have located in Glasgow; one in Burkesville; one in Tompkinsville; and four in Bowling Green. We now have a total of 106 physicians and 90 are paid up members of the Association. We have had four deaths in the district during the year.

Our district meetings are well attended and great interest has been demonstrated in the programs presented during the year. We have

tried to hold our meetings in the various towns in the district, which has greatly added to the attendance. A number of the counties hold monthly programs that are well attended.

The Councilor wishes to thank every member of the profession for the response and cooperation that he has received throughout the year.

Respectfully submitted,
/s/ Lawrence O. Toomey
Lawrence O. Toomey, Bowling
Green, Councilor, Sixth District

SPEAKER HOUSTON: The report has been filed and referred to Reference Committee No.

1. Dr. Baughman, Frankfort, Seventh District.

DR. BAUGHMAN: The report has been filed, and I have nothing to add.

REPORT OF THE SEVENTH COUNCILOR DISTRICT TO THE 1952 SESSION OF HOUSE OF DELEGATES

The second year of the existence of this District finds it on its feet and in relatively good condition except for a shortage of physicians, which is probably common to most of the Districts in Kentucky. There are now 61 physicians in the District, of whom four are not in active practice. The counties, number of physicians and population are shown in the table.

County	Number of Physicians	Population
Anderson	5	8,984
Carroll	6	8,517
Franklin	17	25,933
Gallatin	0	3,969
Grant	5	9,809
Henry	10	11,394
Oldham	5	11,018
Owen	5	9,755
Shelby	7	17,912
Trimble	1	5,148
Total	61	112,439

There are four new physicians in the District since the last annual report: Lawrence E. Oliver, M. D., at Carrollton, O. A. Cull, M. D., at Corinth, Smith Gibson, M. D., at Williamstown and Paul Harrison, M. D., at Owenton. James T. Ramsey, M. D., has recently moved to Frankfort from Owenton to engage in general practice and anesthesia. Harry K. Dillard, M. D., has given up his practice at Warsaw and has taken a position with the Department of Health. At present, there is no physician in Gallatin County, but I am advised that very shortly a young physician, Doctor Bennett, will engage in practice at Warsaw. O. James Hurt, M. D., remains the only physician in Trimble County. It is expected that in the near future Robert L. Houston, Jr., M. D., will be released from Military Service to return to practice with the Henry County Clinic in Eminence.

At present we do not anticipate losing more than one physician within the next year. Within the past year we lost Minnie V. D. Kratz, M. D., of Grant County, who is now in Japan with her husband, Doctor Kratz, who is in the Army. We recently lost, by death, one of the best loved physicians in the District, F. M. Travis, M. D., of Frankfort, Kentucky. Doctor Travis had been engaged in active practice in Frankfort since 1926, when he came to Frankfort as a physician for the Kentucky State Reformatory. He was interested in all phases of the work of the Kentucky State Medical Association. He was an active member, and former President, of the Franklin County Medical Society. He had been a member of the State Board of Health since 1948. He was a specialist in radiology. He will be greatly missed by the people of Frankfort and Franklin County, as well as by his medical colleagues throughout the state.

Every county, or group of counties, of the District has an organized society with duly elected officers and delegates. Of the sixty-one physicians in this District, fifty-five are paid up members of the Kentucky State Medical Association. The Councilor regrets that only forty-three are paid up members of the American Medical Association. We have been unable to visit every society in the District in the past year, but we have been in contact in some manner with all of the doctors in the District.

Our annual meeting was held on June 19, 1952, at the Madison, Indiana, Country Club, with the Carroll County Society as the host society.

About fifty physicians, and wives, were present and we had a delightful meeting. This is a beautiful place overlooking the Ohio River and the food, as well as the general atmosphere, was delightful. Our guest speaker of the evening was the President of the Kentucky State Medical Association, Clark Bailey, M. D., who was accompanied by Mrs. Bailey. He gave a splendid talk which was of great value to all present. Three scientific papers were presented: all by physicians practicing in the District. The physicians in the District are still in favor of having no guest speakers present scientific papers. We believe that this encourages our physicians to do more writing.

The Councilor is gratified that the sale of Blue Cross and Blue Shield contracts continues to increase throughout the counties of the District.

Ground has been broken for the building of a new King's Daughters Hospital in Shelbyville. It will be approximately 60 bed capacity and is greatly needed. Plans are under way to build an addition of 40 to 50 beds to the

King's Daughters Hospital in Frankfort. The new Owen County Hospital has had a splendid year and is running at near full capacity.

The Councilor has sought to keep before the physicians of the District better public relations and a more aggressive attitude in the fight against all forms of Socialized Medicine. The physicians of the District demonstrated their ability to obtain results during the Legislature of 1951-52 and they actively supported the legislative program of the Kentucky State Medical Association. We have sought, and believe we have obtained, the respect and confidence of our people. We urge continued participation by our physicians of all forms of worthwhile civic and community activities.

The Councilor appreciates the help and support of the physicians in his District, and he, also, wishes to thank the Secretary and the Executive Secretary of the Kentucky State Medical Association for their invaluable help.

Respectfully submitted,
/s/ Branham B. Baughman
Branham B. Baughman, Frankfort
Councilor, Seventh District

SPEAKER HOUSTON: Report has been filed and referred to Reference Committee No. 1.

Eighth District, Dr. Mersch of Covington.

DR. MERSCH: The report has been filed.

REPORT OF THE EIGHTH COUNCILOR DISTRICT TO THE 1952 SESSION OF HOUSE OF DELEGATES

The eighth councilor district is composed of Boone, Campbell and Kenton Counties. There is a well organized Medical Society called the Campbell-Kenton. The physicians of Boone County are invited guests to the society which meets monthly except in July and August.

The members of the Campbell-Kenton Medical Society have become affiliated with the Cincinnati Academy of Medicine as associate members. By doing this we have a twenty-four hour service maintained by the Academy. All patients living in Northern Kentucky can locate their doctor, or someone to answer the call through the Academy Exchange—Garfield 6000.

We still have a shortage of physicians in certain areas. There is likewise a shortage of hospital beds, brought about in a large measure by hospitalization insurance. It would seem that further hospital expansions are vitally needed. We have been trying to partially overcome the bed shortage by shortening the hospital stay of the individual patient. A 100 per cent cooperation along this line would

greatly help, but even so additional hospital beds are required.

Respectfully submitted,
/s/ Edward B. Mersch
Edward B. Mersch, Covington
Councilor, Eighth District

SPEAKER HOUSTON: That report is referred to Reference Committee No. 1. Dr. J. R. Cummings, Ninth District.

DR. CUMMINGS: The report has been filed.

REPORT OF THE NINTH COUNCILOR DISTRICT TO THE 1952 SESSION OF HOUSE OF DELEGATES

The Ninth Councilor District held no meeting this year; however, the Councilor met individually with several groups. In attending some of the staff meetings of the Nicholas County Hospital of Carlisle, the Bourbon County Hospital of Paris, and the Hayswood Hospital of Maysville, the Councilor was in contact with members of the societies of the district, including Bath, Nicholas, Bourbon, Fleming, Mason, Bracken, Robertson. In attending the meetings of the Licking Valley Medical Society, the Councilor also was in contact with members from the societies of the counties of Harrison, Scott, and Pendleton as well as some of those already mentioned above.

The meeting held in August at the Bourbon County Hospital, Paris, was especially informative and valuable. Dr. Guthrie Y. Graves of Bowling Green addressed the Bourbon County Medical Society in reference to the Civil Defense Program. The out-of-town guest and speaker was the dinner guest of Dr. and Mrs. N. B. Pittinger of Paris.

By and large the population status of the Ninth Councilor District has changed but little. Some of our older and respected physicians have died, and some new and younger physicians have come in. Medically speaking, the physical status has changed a great deal. One of the finest and best equipped hospitals in the state has been completed at Paris and is now well staffed with a group of physicians who are progressive, forward thinking, and professionally capable. The building program at the Hayswood Hospital in Maysville has been completed, thereby increasing the bed capacity by 35; and a new nurses' home has been erected. The recently constructed Nicholas County Hospital at Carlisle is ably serving the people of that and adjacent counties. The Georgetown Hospital has added 31 beds. New health centers have been built or approved at Flemingsburg, Maysville, Georgetown, and Cynthiana.

The doctors in the district who showed in-

terest and gave much of their valuable time in an endeavor to accomplish the legislative aims of the Kentucky State Medical Association are hereby commended. In my humble opinion, the success attained was in a great measure due to effort at the county level.

The Ninth Councilor District is composed of ten county societies. These societies range in membership from one to sixteen. Of the ten counties, five are equipped with hospitals of the general type, and one county, in addition, has a state tuberculosis sanatorium. It is felt that professional services generally throughout the district have been increased and improved during the past year.

Respectfully submitted,
/s/ John R. Cummings
John R. Cummings, Flemingsburg
Councilor, Ninth District

SPEAKER HOUSTON: That report is referred to Reference Committee No. 1. Dr. J. Farra Van Meter of the Tenth District.

DR. VAN METER: The report is in hand.

REPORT OF TENTH COUNCILOR DISTRICT TO THE 1952 SESSION OF HOUSE OF DELEGATES

District 10, the second largest in the state, is comprised of three counties: Fayette, Woodford and Jessamine. Approximately 217 physicians are in this district. Many of these are in our local Government hospital.

The county societies of Woodford and Jessamine meet at irregular intervals, four or five times a year. The Fayette County Society meets regularly each month. Its membership at present is 174. It is natural, therefore, that the activities in this district center somewhat around this society. Physicians from Jessamine and Woodford frequently attend these meetings.

Following the last annual meeting of the House of Delegates of our State Association, considerable concern and disapproval was expressed by some members of the Fayette County Society of the manner in which the business of the House was carried on. It was felt that certain vital legislation was "railroaded" through, without the delegates being properly informed or given opportunity to discuss such legislation.

Accordingly, the society invited Clark Bailey, M. D., President of the Association, and Bruce Underwood, M. D., Secretary of the Association, to meet with the society and discuss these problems as presented.

This they did, the second Tuesday in December, 1951. It is felt that much good came of this meeting and these officers were able to satisfactorily clarify certain matters. At the same time the society emphasized to them the

necessity of having information dealing with vital legislation in the hands of the delegates at least two weeks before the House convenes. This, the Council has directed be done, and in this way adequate opportunity will be given each delegate to inform himself.

The members of this society have, from time to time, expressed concern over the vast increase in expenditures of the State Association, necessitating increase in annual dues and with evidence of expenditures in excess of even this increased revenue. It is hoped that the Council will be equally concerned about this and will reduce overhead in every practical way.

Respectfully submitted,
/s/ J. Farra Van Meter
J. Farra Van Meter, Lexington
Councilor, Tenth District

SPEAKER HOUSTON: The report is received and referred to Reference Committee No. 1. The Eleventh District, Dr. Mahaffey of Richmond, Kentucky. It has been filed and referred to Reference Committee No. 1.

REPORT OF ELEVENTH COUNCILOR DISTRICT TO THE 1952 SESSION OF HOUSE OF DELEGATES

As of September 25, the Eleventh District is composed of ten counties and has 60 doctors who are members of the State Medical Association. Last year the total number of paid members was 59. Of the present, 43 have paid their A.M.A. dues. The Eleventh District is a new district composed of Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell and Wolfe counties. At the present time only five counties have organizations and actually only three counties, Clark, Montgomery and Madison, have regular meetings.

We are planning our Annual Eleventh Councilor District Meeting in November.

It appears that the number of people purchasing voluntary Health Insurance continues to increase. This is not true of the counties outside of hospital centers in our district, however.

Respectfully submitted,
/s/ Hugh Mahaffey
Hugh Mahaffey, Richmond
Councilor, Eleventh District

SPEAKER HOUSTON: Dr. Carl Norfleet, Twelfth District.

DR. NORFLEET: The report of the Twelfth District is filed with the Secretary.

REPORT OF THE TWELFTH COUNCILOR DISTRICT TO THE 1952 SESSION OF HOUSE OF DELEGATES

The Twelfth Councilor District is composed of eleven counties. According to a recent report from the office of the Kentucky State

Medical Association there are 112 doctors in this district, 83 of whom are members of their County and State Medical Societies. 68 have paid their A.M.A. dues and 29 are non-members. Some of the non-member group have retired, some are semi-active due to age and infirmity and others have failed to qualify.

I am sorry to have to report that one county has failed to elect officers, hold meetings, or report payments of any County or State dues. Therefore, the six doctors in this county are included in the list of non-members. It is hoped that they will qualify before this House of Delegates meets.

Death has claimed three members of our profession from this District during the past year—Dr. Walter R. Cundiff, class of 1907, Somerset, Kentucky, Dr. Augustus J. Wahle, class of 1908, Somerset, Kentucky and Dr. Bradley B. Montgomery, class of 1911, Lancaster, Kentucky.

Seven doctors have located in various counties of this District during the past year.

Some of the County Medical Societies have held regular meetings while others have met sporadically.

The Twelfth Councilor District Annual Meeting sponsored by the Pulaski County Medical Society was held on June 26, 1952 at the Seven Gables Restaurant overlooking Lake Cumberland, Burnside, Kentucky. The meeting was fairly well attended and all present enjoyed a comfortable, commodious, air conditioned assembly room and a delicious, sizzling T-bone steak dinner. Our guest speakers were, Dr. Clark Bailey, President, Kentucky State Medical Association, Harlan, Kentucky, subject, "Transition of Medicine" and Dr. Henri LeClaire, Radiologist, Cincinnati, Ohio, subject, "The Management of Cancer of the Skin." A very interesting and enjoyable program was rendered.

Dr. Oscar L. May, Danville, Kentucky, was elected president and Dr. M. C. Spradlin, Somerset, Kentucky, secretary of the Twelfth Councilor District for the ensuing year.

Following an invitation by Dr. May the Councilor District voted to hold its next annual meeting under the sponsorship of the Boyle County Medical Society in June, 1953 at a place to be determined later.

Telephone Seminars were enjoyed by the medical societies of four or five counties in this District during February, March and April of this year.

The new hospital at Albany, Kentucky, is about ready for occupancy.

Two new County Centers have been completed and opened to the public during the past two months, namely, Pulaski and Boyle County Health Centers.

Much correspondence, telephone service and

many visits of inquiry, investigation, interviews, conferences and meetings pertaining to the business incurred as Councilor of the Twelfth District have kept your servant quite busy. The task has been arduous, though pleasant. It afforded an opportunity to obtain the confidence and closer relationship with individuals and groups of the medical profession of our District. Many perplexing problems have arisen, solutions of which have been attempted and in some instances were successfully solved.

To observe and know the function of an organization that has the magnitude of the Kentucky State Medical Association and to realize that one is a factor in the promotion of its objectives and accomplishments is a privilege to be appreciated.

Respectfully submitted,
/s/Carl Norfleet
Carl Norfleet, Somerset
Councilor, Twelfth District

SPEAKER HOUSTON: Report is referred to Reference Committee No. 1.

Dr. Clyde Sparks, Ashland, Thirteenth District.

DR. SPARKS: Mr. Speaker, the report has been filed with the Secretary.

REPORT OF THE THIRTEENTH DISTRICT TO THE 1952 SESSION OF HOUSE OF DELEGATES

One district meeting was held in the district since the last annual meeting and was well attended, and, apparently, very well received. The speakers presented very clear and well-organized subject matter. The President of the State Association was present and his remarks were very timely, and we believe the meeting was extremely worthwhile, both scientifically and from the standpoint of appreciation of the importance of organized medicine. The Councilor is particularly grateful to the help of the Boyd County Medical Society and its Woman's Auxiliary, who sponsored this meeting.

Some of our counties are very much in need of additional medical personnel, and the combination of advancing years and death is exceeding in this district the rate at which more youthful replacements are being secured.

Hospital facilities in this district are being materially increased and improved, and this should be of value in attracting younger men to some of the outlying districts. We have lost three members by death during the last year.

Respectfully submitted,
/s/ C. C. Sparks
Clyde C. Sparks, Ashland
Councilor, Thirteenth District

SPEAKER HOUSTON: It is referred to Reference Committee No. 1, Dr. Paul B. Hall, Paintsville, Fourteenth District.

SPEAKER HOUSTON: His report is here and referred to Reference Committee No. 1.

**REPORT OF THE FOURTEENTH COUNCILOR
DISTRICT TO THE
1952 SESSION OF HOUSE OF DELEGATES**

Your Councilor of the Fourteenth District wishes to report to the delegates of the Kentucky State Medical Association that the general health and medical situation in Eastern Kentucky is in good condition. Your Councilor has been rather busy, obtaining information as to the availability of physicians for military service, and has investigated and reported on twenty or thirty physicians. This necessitates a trip to the home of the physician and an interview with several doctors and citizens.

The United Mine Workers Welfare Program has added a rather heavy load to the hospitals and doctors here in Eastern Kentucky. We still have an alarming shortage of physicians and younger men are being called to the service all the time and we do not have too many new men coming into this field. I still think this is a rather serious situation and if the Medical Profession as a whole could do anything about it, it should be done. By that, I mean the graduation of more doctors. Roughly speaking, I feel like we only have about fifty per cent of the doctors in my Councilor District that we really need to render the citizens the medical services they are entitled to have.

We have tried to carry out the routine duties of a Councilor by answering all of our correspondence and by attending the Councilor Meetings at Louisville and doing whatever we could in the interest of good medicine. We are much pleased about the fact that we think socialized medicine has received a good set back in the past few months.

Respectfully submitted,
/s/ Paul B. Hall
Paul B. Hall, Paintsville
Councilor, Fourteenth District

SPEAKER HOUSTON: Dr. Edward Wilson, Pineville, Fifteenth District. Is Dr. Wilson here? His report is here, and is being referred to Reference Committee No. 1 for study.

**REPORT OF FIFTEENTH COUNCILOR
DISTRICT TO THE
1952 SESSION OF HOUSE OF DELEGATES**

The Fifteenth Councilor District is composed of seven counties, namely Bell, Clay, Harlan,

Knox, Laurel, Leslie and Whitley. These counties are in the southeast corner of the state. Two of these counties have less than five physicians. Clay County has three physicians, Leslie County has two, Bell County has thirty-two physicians, Harlan County has forty-nine, Knox County has nine, Laurel County has eleven, Whitley County has twenty physicians. Some of these physicians are retired and some are on limited license. It has been a big enigma as to what to do with our limited licensed practitioners.

We have in this District three hospitals in Bell County, two in Middlesboro and one in Pineville. We have been very much employed in trying to complete the Pineville Community Hospital, which will have one hundred thirty beds.

I feel that I have not done as much as Councilor as I should have, because of the burden of building and remodeling the Pineville Community Hospital. I hope to be able to do more in the next year.

Respectfully submitted,
/s/ Edward Wilson
Edward Wilson, Pineville
Councilor, Fifteenth District

SPEAKER HOUSTON: You will now have the report of the Delegate to the A.M.A., Dr. J. Duffy Hancock, Louisville. Dr. Hancock.

**REPORT OF DELEGATE TO A.M.A.
TO THE
1952 SESSION OF HOUSE OF DELEGATES**

DR. HANCOCK: Mr. Speaker, members of the House, at the interim Clinical Session in December 1951, all three of your delegates: J. B. Lukins, M. D., Bruce Underwood, M. D., and J. Duffy Hancock, M. D., were in attendance. They also attended the one-day Public Relations Meeting which preceded the official A.M.A. Meeting.

We were asked by the Kentucky Chapter of the Academy of General Practice to re-introduce a resolution asking for a conference with the Blue Cross regarding compensation for the use of a physician's physical facilities as distinguished from his professional services. The request seemed most reasonable to us and a proper resolution was presented. We received a very fair hearing before the reference committee and were allowed to present D. G. Miller, M. D., to further plead our position. However, we encountered the same opposition as before—a hesitancy to allow the Blue Cross to have anything to do with physicians' bills. The resolution was not approved but the reference com-

mittee did state officially that it was their opinion that procedural technique was available to consider this at the State level. We hope that such can be accomplished.

Your delegates, as requested, introduced another resolution which would permit members who were delinquent to rejoin The American Medical Association by payment of dues for the current year without penalty or prejudice. This caused a prolonged discussion in the reference committee. Delegates from many other states were there to present their views — mostly favorable. The committee, however, refused to approve such a blanket forgiveness of delinquent dues. It did, though, recognize that there were misunderstandings because of the confusion between assessments and dues and offered a substitute motion that was approved by the House. This authorized the Secretary of the A.M.A. to negotiate with each state organization separately as to methods of correcting misunderstandings which exist relative to the collection of 1950 dues only. It was our impression that wide latitude was to be given to the interpretation and adjustment of these misunderstandings.

Much time was spent in a consideration of necessary changes in the Constitution and By-Laws of the Association.

Among the distinguished guests presented to the House of Delegates was Mr. Donald Wilson, National Commander of the American Legion. In a dynamic talk he pledged his organization to stand shoulder to shoulder with us in the fight against the creeping menace of the encroaching forces of socialism.

Dramatic talks were given by Senators Taft and Byrd at the public night session. It was reassuring to see the reception of the public to these arguments against bureaucratic and socialistic trends.

President Cline directed attention to the increasing enrollment in voluntary health plans.

The scope of The American Medical Education Foundation was again explained and contributions from state organizations as well as individuals were solicited.

A very comprehensive report on the entire question of blood banks was given.

A report of the activities of the American Medical Association's National Education Campaign was presented. The accomplishments of this effort were recognized as the deciding factor in turning the trend away from socialized medicine. Whitaker and Baxter, who had directed the campaign, were retained on a part-time basis.

We are glad to report that there was a general feeling of optimism regarding the future of private practice.

This second report deals with the 1952 session held in June at Chicago.

At the June 1952 meeting, Kentucky was entitled to only two delegates, Bruce Underwood, M. D., and J. Duffy Hancock, M. D. Both were present at all official meetings of the House of Delegates and Clark Bailey, M. D., and Mr. Joseph Sanford were also present in an unofficial capacity.

Before the meeting we were contacted by two of our local groups. The pathologists were concerned about a reported movement for their Board to accept others than M. D.'s for certification. As this matter was presented by delegates from several other states we did not see the necessity for introducing a duplicate resolution. This question together with a request for a definition of the limits of oral surgery by those with only a dental degree were referred to proper committees for further study.

The other matter was brought to our attention by physicians in Eastern Kentucky. They were interested in deferring any approval of the Memorial Hospital program of the United Mine workers until the subject had been thoroughly studied. Since no resolution of this nature was introduced, your delegates did not bring up the subject officially but did listen to informal discussion about the matter. Both delegates were present at the meeting in West Virginia where the entire problem was discussed and you will be advised in another report by the entire committee regarding those proceedings.

Probably the most dramatic part of the meeting was the discussion concerning the President's Commission of Health Needs of the Nation. While the resolution finally adopted was not so strongly worded as some had wished, it was a dignified, unequivocal endorsement of the active opposition that had been waged by the officers of the A.M.A. This was entirely in keeping with the alert aggressive morale of the whole organization in its fight against all phases of state socialism.

Dues for active members were continued at \$25 per annum. This includes subscription to the Journal of the American Medical Association in lieu of which one of the other scientific journals of the Association can be substituted if so requested. Fellowship in the A.M.A. was discontinued.

The delegates endorsed the action of the Board of Trustees in opposing H. R. 7800, not because of the raise in Social Security benefits but because of a trick rider that really opened a back door to socialized medicine.

The delegates endorsed the action of its Board of Trustees. We were put in a very bad light, particularly by local papers, because of our opposition to this resolution. It was not

because the benefits were raised, but it was because of the power which would be given to Mr. Ewing or his successor in appointing the men to make the examinations in these cases.

While nothing definite has yet been accomplished regarding deductible payments by professional men for self-provided retirement pensions, efforts are continuing to accomplish this equitable and fair piece of proposed legislation.

I might explain here that the American Bar Association is working hard on this, that both Mr. Stevenson and General Eisenhower have been contacted, that both seem to understand the problem which has been presented, and that both have promised to make a statement later in the campaign. For the benefit of those of you who will take sufficient interest to speak to the Congressional candidates in your particular district, these bills were the Koegh and Reed bills. They were identical bills introduced in the House, and the purpose of them was to allow a professional man or a self-employed man—not just doctors—to deduct from his income a certain amount of money not to exceed \$7,500 a year which could be deducted and saved tax-free to purchase a pension to come on later in life, at which time the income from the pension would be taxable. It is simply an attempt to give the self-employed the same advantage that the workman has or that the officials of the management of large companies have to provide their own pensions later on.

We were alerted to the inherent dangers of suggestions for socialized medicine as considered by the International Labor Organization. Your Chairman of the Council, Dr. Sparks, has already elaborated on that.

Our attention was again directed to the importance of adequate contributions in the American Medical Education Foundation.

Your delegates to the American Medical Association have but one recommendation to make to the delegates of the Kentucky State Medical Association. It is that each of you act as a committee of one to encourage increased membership in the American Medical Association. It will be of mutual help to all and at times like this it is most essential that we present a united front.

SPEAKER HOUSTON: Thank you, Dr. Hancock. The Speaker will refer his report to Reference Committee No. 1 for study and recommendations.

I now have the ballot on the Distinguished Service Award and the J. Watts Stovall Award.

In the Distinguished Service Award, 89 were voting. Dr. John Scott got 59, Dr. O'Nan 26, and Dr. Howard 14. It is a majority in this

award, and Dr. Scott will be the recipient of our Distinguished Service Award.

For the J. Watts Stovall Award, 85 were voting. Dr. Sherman got 32, Dr. Bates got 35, and Dr. Jones got 18. There is not a majority. I will ask Dr. Morris to please scatter the ballots again for the revoting on the two top men, Dr. Sherman and Dr. Bates.

We are now ready for the reports of the Standing Committees. We will ask Dr. R. Haynes Barr to make the report of the Committee on Arrangements. Dr. Barr.

DR. BARR: Mr. Speaker, members of the House of Delegates, the report of the Committee on Arrangements has been filed and is in the bag. In the morning at the opening session there will be some announcements made of more recent vintage of this report, which I believe will cover the field more thoroughly, and I think that our attendance will be larger at that time.

REPORT OF COMMITTEE ON ARRANGEMENTS TO THE 1952 SESSION OF HOUSE OF DELEGATES

The Committee on Arrangements has undertaken making the arrangements for the 1952 Annual Meeting, which will honor Daniel Drake, M. D.

The scientific sessions, the scientific and technical exhibits, all meetings of the House of Delegates and the Reference Committees, the scientific movies and various other functions are being held at the Columbia Auditorium.

The General Public Meeting will be held at the Columbia Auditorium Tuesday, October 7, at 8:15 P. M. Colonel Gerald M. McDonnell will be the guest speaker and his subject will be "Medical Aspects of Atomic Defense." The three awards of the Association will also be presented—the E. M. Howard Award, the J. Watts Stovall Award and the Distinguished Service Medal.

The President's Luncheon will be held on the Roof Garden of the Brown Hotel Wednesday, October 8. Mr. T. Russ Hill will address our members on the subject "Bulwarks." Mr. Hill is a native of Kentucky and a Detroit industrialist.

The Woman's Auxiliary will hold its annual session at the same time as our meeting. They have handled their own arrangements with the Brown Hotel.

For members who play golf, the Annual Golf Tournament has been arranged at Big Springs October 7, 8 and 9.

The Annual Banquet will take place Thursday evening in the Crystal Ball Room of the Brown Hotel at 7:30 P. M. The President of our Association, Clark Bailey, M. D., will deliver his address "Which Direction?" at this

time. Features of this meeting include the "Charge to New Members," presentation of golf prizes, and the installation of the new President.

A string quartet will provide background music for the evening.

Respectfully submitted,
COMMITTEE ON ARRANGEMENTS

/s/ R. Haynes Barr

R. Haynes Barr, Owensboro,
Chairman

Joseph C. Bell, Louisville

Charles M. Edelen, Louisville

Keith Smith, Corbin

William H. Pennington, Lexington

SPEAKER HOUSTON: The Speaker refers this report to Reference Committee No. 2.

We are now ready for the report of the Committee on Scientific Assembly, Dr. Clark Bailey.

DR. BAILEY: Mr. Speaker, and members of the House, it is the feeling of our Committee that we are presenting to you a most balanced program for your scientific program, certainly one that will be most enjoyable and most instructive and most constructive.

I want to call your attention to the open meeting tomorrow evening which you will hear more about. That is dedicated to a program of civil defense. The Governor asked our Association to do our part, and this program is arranged for your benefit. At the President's luncheon on Wednesday it is hoped that all of the members will attend. Dr. Louis H. Bauer, President of A.M.A., was unable to attend the meeting, and we have a most outstanding speaker in T. Russ Hill, President of the Martin-Parry Corporation, very inspiring and should bring us a wonderful message.

Of course we have the annual banquet Thursday evening, which we hope you will attend. We feel we are bringing to you a well-rounded program that will attract many doctors from over the State of Kentucky.

REPORT OF THE COMMITTEE ON SCIENTIFIC ASSEMBLY TO THE 1952 SESSION OF HOUSE OF DELEGATES

Your Council approved the request of the Committee to invite sufficient participants of national repute in the various fields of medicine to complement our basic program. It is our opinion that in following this procedure a scientific session has been arranged which is most attractive and desirable. The program is submitted to the delegates and members of the Association for their approval:

SCIENTIFIC PROGRAM

Tuesday, October 7, 1952

9:00 Opening of Convention

9:30 "Diet and Arteriosclerosis, with Special Reference to Coronary Arteriosclerosis"

—Alfred Steiner, M. D., New York, New York

10:00 "Mitral Stenosis"—Its Surgical Correction—W. Burford Davis, M. D., Louisville, Kentucky

10:30 Visit the Exhibits

11:00 "Obstetrical Anesthesia in General Practice"—Warren F. Sergeant, M. D., Lexington, Kentucky

11:30 Oration in Medicine—"The General Practitioner Sees the Hypertensive Patient"—Joseph M. Bush, M. D., Mt. Sterling, Kentucky

12:00 Adjournment

2:00 "The Diagnosis of Lung Lesions"—Paul Crimm, M. D., Evansville, Indiana

2:30 "Carcinoma of the Cervix Uteri (Newer Ideas of Management)"—Jesshill Love, M. D., Irvin H. Sonne, M. D., Robert Greco, M. D., Louisville, Kentucky

3:00 Visit the Exhibits

3:30 "Infectious Hepatitis — Epidemiology, Diagnosis and Treatment"—Richard B. Capps, M. D., Chicago, Illinois

4:00 "Functional Fixation of Fractures of Upper Extremities"—William K. Massie, M. D., Lexington, Ky.

4:30 Adjournment

Wednesday, October 8, 1952

9:00 "The Duties and Responsibilities of the Doctor and the State Medical Association in Civil Defense"—G. Y. Graves, M. D., Bowling Green, Kentucky

9:15 "Civil Defense Health Service and Special Weapons Defense"—Norvin Kiefer, M. D., Washington, D. C.

9:45 "Management of Casualties in Korea"—Col. Frank E. Hagman, Denver, Colorado

10:10 "The Civil Defense Blood Program"—John L. Alsever, M. D., Washington, D. C.

10:30 Visit the Exhibits

11:00 Oration in Surgery—"Geriatric Surgery"—Gaithel L. Simpson, M. D., Greenville, Kentucky

11:30 Adjournment

12:00 President's Luncheon

2:00 "Advances in the Surgical Management of Carcinoma of the Colon"—Eugene Bricker, M. D., St. Louis, Missouri

2:30 "Rural General Practice, in 1952"—George Bond, M. D., Bat Cave, North Carolina

3:00 Visit the Exhibits

3:30 "The Doctor's Day in Court"—Judge L. R. Curtis, Louisville, Kentucky

4:00 "Practical Aspects in the Treatment of Meningitis in Children"—Robert N. McLeod, Somerset, Kentucky

4:30 Adjournment

Thursday, October 9, 1952

9:00 "Public Health Policies"—Bruce Underwood, M. D., Louisville, Kentucky

- 9:30 "Rationale of Good Control in the Treatment of Diabetes Mellitus"—Arthur R. Colwell, M. D., Chicago, Illinois.
- 10:00 "Otalgia"—William L. Woolfolk, M. D., Owensboro, Kentucky
- 10:30 Visit the Exhibits
- 11:00 "ACTH and Cortisone"—Cyril M. MacBryde, St. Louis, Mo.
- 11:30 "Modern Treatment of Burns"—Roy H. Moore, Jr., M. D., Louisville, Ky.
- 12:00 Adjournment
- 2:00 "Encouraging and Discouraging Research with Therapeutic Radioisotopes"—Marshall Brucer, M. D., Oak Ridge, Tenn.
- 2:30 "Endocrinology Phases of Gynecology"—W. O. Johnson, M. D., Louisville, Kentucky
- 3:00 "When a Psychiatric Case Walks into Your Office"—Billy K. Keller, M. D., Louisville, Kentucky
- 3:30 "Surgery of the Hand"—Richard J. Rust, M. D., Newport, Kentucky
- 4:00 Adjournment

Respectfully submitted,

COMMITTEE ON SCIENTIFIC
ASSEMBLY

/s/ Clark Bailey

Clark Bailey, Harlan, Chairman
R. Haynes Barr, Owensboro
Thomas O. Meredith, Harrodsburg
Morris Flexner, Louisville
Bruce Underwood, Louisville
Secretary

SPEAKER HUSTON: The Speaker refers this report to Reference Committee No. 2.

The Public Relations Committee, Dr. R. Haynes Barr.

DR. BARR: Mr. Speaker, members of the House of Delegates, report of the Public Relations Committee has been filed, received, and it is contained in the envelope which you were given.

**REPORT OF THE PUBLIC RELATIONS
COMMITTEE TO THE
1952 SESSION OF HOUSE OF DELEGATES**

Soon after the last Annual Meeting the Council, noting that during a Legislative year the Legislative Committee would be engrossed in a tremendous undertaking of its own and, also, noting that the purpose and function of the Education Sub-Committee would be somewhat different than it had been during the past two or three years, very wisely came to the decision that the Public Relations Committee, the Education Committee and the Legislative Committee would be constituted separate entities, each with equal rank and importance. This change in organization allowed the Public Relations Committee, for the first time, to think and work in a somewhat broader sphere, doing

purely Public Relations and working in cooperation with any of the various committees having a Public Relations angle to their field of endeavor.

In consequence, the Public Relations Committee first worked during the session of the General Assembly with the Legislative Committee in framing public opinion over the State, which would react favorably upon the members of the General Assembly to the end that legislation sponsored by this Association could be successfully passed. The success of the Legislative Committee need not be related here.

Immediately upon the culmination of the legislative effort, this Committee lent all possible assistance in a most successful Annual Conference of County Medical Society Officers, which Conference was attended by some leading national figures in the field of leadership in public relations, including the President and past President of several of our neighboring State Associations, as well as representatives from the Public Relations Division of the American Medical Association and the President of the American Medical Association. The theme of this entire Conference was Public Relations.

Closely following upon the heels of this meeting, the Public Relations Committee gave all-out assistance to the Committee on Rural Health, which organized and put on a Conference May 7, 1952. This Rural Health Conference was sponsored by the Committee on Rural Health of the Kentucky State Medical Association, and was joined in the sponsorship by eleven other state-wide organizations, including the Farm Bureau, the Hospital Association, the Home-makers, and a great many others of our health-minded agencies. This Conference was widely hailed by the press, as well as the members of our co-sponsoring agencies, as a very fine move in the direction of better health for all of the people in rural areas. In my opinion, it was Public Relations at its best.

Working with both the Committee on Arrangements and the Committee on Scientific Assembly, in setting up plans for the 1952 Annual Meeting, the Public Relations Committee was consulted as to the Public Relations effort of certain of the open meetings and radio and press coverage for this meeting. It is hoped that this 1952 meeting will be quite successful from a Public Relations point of view.

The Public Relations Committee has worked with the Woman's Auxiliary in several very fine accomplishments; namely, an essay contest on Americanism, a contest among college newspapers centering around free enterprise, and the great American way.

The Chairman of the Public Relations Committee has addressed the Kentucky Broadcast-

ers Association annual meeting, the Kentucky Chapter of the National Medical Technologists in their annual meeting, and has talked to several of the larger civic organizations of the state, during the past twelve months. Other members of the Public Relations Committee have also been busily engaged in speaking to many groups on the subject of Health, Medical Care, and Americanism.

Members of this Committee have also appeared before many County Societies, talking on Good Citizenship, Good Public Relations, and Good Medical Service for the people.

Respectfully submitted,
PUBLIC RELATIONS COMMITTEE
/s/ R. Haynes Barr

R. Haynes Barr, Owensboro, Chr'n.
Glenn Bryant, Louisville
David Cox, Louisville
William Pennington, Lexington
Edward Wilson, Jr., Pineville

SPEAKER HOUSTON: The Speaker refers that report to Reference Committee No. 2 for study.

We will have the report of the Committee on Medical Service, Dr. G. L. Simpson. He has been requested to read this report.

REPORT OF THE COMMITTEE ON MEDICAL SERVICE TO THE 1952 SESSION OF HOUSE OF DELEGATES

DR. SIMPSON: Members of the House of Delegates, of the many subjects considered this year, three were considered worthy of report at this time.

On January 1, 1952, we received the following communique from the Council: "You are responsible for study and recommendations concerning the following subjects as is related to the people of Kentucky in their relationship to the K.S.M.A.

- (1) Medical Education
- (2) Indigent Medical Care
- (3) Tuberculosis
- (4) Mental Illness
- (5) Chronic Diseases
- (6) Public Health
- (7) Cerebral Palsy
- (8) Crippled Children
- (9) Hospital, Health Center, and Facilities for Physicians
- (10) The Medical Phases of (a) Vocational Rehabilitation
 - (b) Economic Security
 - (c) Welfare Department"

To the group of ten, our Committee added No. 11, "Veterans Hospital Program" and No. 12, "Rural Hospitals in Kentucky."

This is a continuation of an expansion of the program that this committee initiated last year. It is obviously impossible to consider these sub-

jects simultaneously, and it seems logical that the first step is to spot-survey the state to determine the number of indigent and medically indigent who are receiving inadequate medical care. Secondly, what is being provided in each county in respect to facilities for medical care and funds to provide same. Who is at present receiving what, from whom, and provided by whom, and much other related and pertinent data. We secured assistance from the Medical Service Committee of the American Medical Association and others, and are laying the groundwork for the survey, but are not at this time—August 15, 1952—in a position to present a finished plan to the House of Delegates for definite action.

Recently within the last few days we have received a communique from the Medical Service Committee of the American Medical Association which met around the 20th of September concerning the request which we had mailed to them asking their participation in a joint survey of this problem. They have indicated that the American Medical Association Committee on Medical Care will participate with us, and we hope to have the survey completed before the meeting of the next General Assembly of Kentucky.

It is the hope of this committee that the survey can be made jointly with other interested groups such as the Kentucky State Dental Association, Kentucky Pharmaceutical Association, Kentucky Hospital Association, PTA, Organized Labor, Kentucky Farm Bureau, Federated Women's Clubs, etc., and when completed may be used as an instrument to secure from the next general assembly, funds earmarked for care of indigent and medically indigent, provided by the state, and administered on a local county basis, and furthermore, the data from the survey can be used to resolve problems connected with several of the lists of subjects furnished by the Council. It is the hope of this committee that the House of Delegates appreciates the vastness of this study and that it cannot be completed in a short time.

II. The Blue Cross-Blue Shield program has been wonderfully successful in Kentucky, but study by our committee revealed that the subscriber has been covered only to the extent of 80 to 82%. The charges not covered by either contract were of a controversial nature as relates to corporation practice, etc. Through cooperation of Blue Cross-Blue Shield and this committee, a solution has been found for more complete coverage which should be in effect before too long, and adds to those benefits already in existence, diagnostic x-ray—with possibly some limitation—tissue studies, EKG, and anesthesia.

This committee would like to recommend for

your consideration a plan of full coverage to be offered jointly by the profession and the hospitals of Kentucky through their respective plans, Blue Shield and Blue Cross.

III. Veterans Administration Hospital Program.

We would like to recommend the House of Delegates go on record and present resolutions to our legislators in Washington, and to the Medical Association of our various sister states concerning Veterans Administration Medical Practice as it relates to private practitioners of our profession and more especially, to our public hospitals, and that the resolutions embrace the following considerations and others as might be deemed desirable.

Resolutions:

- I. (a) Confine admissions and treatment to veterans with service connected disabilities.
(b) Possible exceptions—mentally ill, TB and other chronic illnesses requiring long periods of hospitalization.
(c) Provide some form of prepaid insurance to the indigent and medically indigent veteran and allow him to receive care at a public hospital of his choice. Discontinue entirely care of the non-service connected disability except indigent and the medically indigent.
- II. Improvement in the program for care of the service connected disability, particularly as relates to rehabilitation, etc.
- III. Discontinuance of the expansive program of building large numbers of Veterans Administration beds. These hospitals would be unnecessary to care for veterans with service connected disabilities and may prove a powerful argument for federal hospital care, in some form, at some later date—many of these beds are now not filled.

That is not true of this community here, but there are Veterans hospitals, particularly in the West, that are not being kept full at this time.

IV. The Veterans Hospital Program is in direct and strong competition with public hospitals, especially in outlying and smaller communities. If allowed to continue, it may in some instances finally interfere with normal growth of the community hospitals. Our secondary, smaller, public hospital program should be well developed if we ever anticipate atomic conflict which would necessarily involve the larger towns and cities initially—and in which places practically all of the Veterans hospitals are placed—under these conditions, many casualties would be directed to smaller hospitals in adjacent communities.

As chairman I want to thank the members of the committee for their splendid cooperation

and support. We are also grateful for the interest and help the officers of the Association have contributed to our work.

Respectfully submitted,
COMMITTEE ON MEDICAL
SERVICE

/s/ G. L. Simpson

G. L. Simpson, Greenville,
Chairman

Alfred Miller, Louisville

John E. Haynes, Dawson Springs

Walter Cawood, Harlan

Cy Waldrop, Williamstown

SPEAKER HOUSTON: The report will be referred to Reference Committee No. 2. I am sure this report contains some things that some of you would like to discuss.

I now have the selection of the J. Watts Stovall recipient, Dr. C. L. Sherman, 46 votes, and Dr. Bates, 44 votes. Dr. Sherman is the recipient of that award.

We now have the report of the Committee to Study the Constitution and By-Laws, and it has been requested that this report be read. Dr. Guy Aud.

DR. AUD: Gentlemen, in the report of the Committee, I think the things that will be most interesting to you will be the resolution. This is going to be rather dry because of the fact of quoting numbers, because of the fact the resolution itself doesn't include all of the paragraphs from which the changes were suggested. We suggested several paragraphs, numbering the paragraphs.

REPORT OF COMMITTEE TO STUDY THE CONSTITUTION AND BY-LAWS TO THE 1952 SESSION OF HOUSE OF DELEGATES

We recommend the following changes in the By-Laws: (1) Delete the words "a nominating committee" from section (4) of Chapter IV of the By-Laws and change section (5) of Chapter V to read as follows:

Section (5)—During the last session of the House of Delegates the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which by ballot the House of Delegates shall select five members to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as Chairman. The nominating committee shall submit its report in writing to all members of the House of Delegates at the first meeting of the House of Delegates and shall submit one or more names for each officer to be elected. Additional nominations may be made from the floor by submitting the nomination without discussion or comment.
Note: (This change provides for a nominating

committee selected by the House of Delegates.)

(2) Change section (14) of Chapter IV of the By-Laws to read as follows:

Section (14)—The state shall be divided into the following councilor districts:

No. 1—Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken and Marshall.

No. 2—Daviss, Hancock, Henderson, McLean, Ohio, Union and Webster.

No. 3—Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd and Trigg.

No. 4—Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Spencer, Taylor and Washington.

No. 5—Jefferson.

No. 6—Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalfe, Monroe, Simpson and Warren.

No. 7—Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby and Trimble.

No. 8—Boone, Campbell and Kenton.

No. 9—Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott and Robertson.

No. 10—Fayette, Jessamine and Woodford.

No. 11—Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell and Wolfe.

No. 12—Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell and Wayne.

No. 13—Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan and Rowan.

No. 14—Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry and Pike.

No. 15—Bell, Clay, Harlan, Knox, Laurel, Leslie and Whitley.

Councilor district meetings may be held as desired and District Medical Associations may be organized as desired according to the districts outlined above.

Note: This change is to list in the By-Laws the present Councilor Districts as now constituted.)

(3) Change section (4) of Chapter V to read as follows:

Section (4)—The election of officers shall be held during the closing session at the regular annual meeting of the House of Delegates.

Note: (This change is to make the By-Laws conform to the present practice of the House of Delegates.)

(4) Change section (1) of Chapter VII of the By-Laws to read as follows:

Section (1)—The Council shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall

exercise the powers conferred on the House of Delegates by the Constitution and By-Laws. The Council shall consist of the duly elected councilors. The President, the President-Elect, the immediate Past-President, the Speaker and Vice-Speaker of the House of Delegates, the Secretary, the Treasurer and the Delegates to the American Medical Association shall be ex-officio members of the Council with the right to vote. The Executive Committee of the Council shall consist of the President, the President-Elect and the Secretary of the Association, together with the Chairman of the Council, Vice-Chairman of the Council and two additional councilors to be elected annually by the Council.

Note: (These changes are to provide a more representative Executive Committee.)

(5) Change section (12) of Chapter XII of the By-Laws to read as follows:

Section (12)—At the time of the annual election of officers each component society shall elect a delegate or delegates to represent it in the House of Delegates of the Association in the proportion of one delegate to each twenty-five members or major fraction thereof provided, however, that each component society shall be entitled to at least one delegate regardless of the number of members it may have and the secretary of the society shall send a list of such delegates to the secretary of this Association on or before April 1 of each year.

Note: (This change is to assure small county medical societies at least one delegate.)

We further recommend adoption of the following resolution:

WHEREAS, Section (1) of Chapter V states that "the terms of the councilors shall be so arranged that one-third of their terms expire each year insofar as possible;"

WHEREAS, at the present time the terms of the councilors expire as follows:

(1) The term of the councilor of district 10 expires in 1952.

(2) The terms of the councilors in districts 1, 2, 3, 4, 7, 9, 11, 12, 13 and 14 expire in 1953.

(3) The terms of the councilors 5, 6, 8, and 15 expire in 1954.

NOW THEREFORE, be it resolved that the speaker of the House of Delegates be authorized and instructed to appoint a committee of three members to determine by lot which of the following councilor districts - 1, 2, 3, 4, 7, 9, 11, 12, 13 and 14 - shall elect councilors at the 1953 Annual Session for the following terms: five for three years; four for two years; one for one year. Provided, however, that all councilors shall be elected thereafter for full three-year terms as provided by Chapter V, Section 1, of the By-Laws. Provided that councilors elect-

ed for one and two year terms shall thereafter be eligible for a full three year term.

Respectfully submitted,

COMMITTEE TO STUDY THE
CONSTITUTION AND BY-LAWS
/s/ Guy Aud

Guy Aud, Louisville, Chairman

R. Haynes Barr, Owensboro

Hugh L. Houston, Murray

Charles Stacy, Pineville

Bruce Underwood, Louisville

RESOLUTION TO THE 1952 SESSION OF HOUSE OF DELEGATES

WHEREAS, Section (1) of Chapter V states that "the terms of the councilors shall be so arranged that one-third of their terms expire each year insofar as possible;"

WHEREAS, at the present time the terms of the councilors expire as follows:

(1) The term of the councilor of district 10 expires in 1952.

(2) The terms of the councilors in districts 1, 2, 3, 4, 7, 9, 11, 12, 13 and 14 expire in 1953.

(3) The terms of the councilors 5, 6, 8 and 15 expire in 1954.

NOW THEREFORE, be it resolved that the Speaker of the House of Delegates be authorized and instructed to appoint a committee of three members to determine by lot which of the following councilor districts - 1, 2, 3, 4, 7, 9, 11, 12, 13 and 14 - shall elect councilors at the 1953 Annual Session for the following terms: five for three years; four for two years; one for one year. Provided, however, that all councilors shall be elected thereafter for full three-year terms as provided by Chapter V, Section (1), of the By-Laws. Provided further that councilors elected for one and two year terms shall thereafter be eligible for a full three-year term.

Respectfully submitted,

COMMITTEE TO STUDY CON-
STITUTION AND BY-LAWS
/s/ Guy Aud

Guy Aud, Louisville, Chairman

R. Haynes Barr, Owensboro

Hugh L. Houston, Murray

Charles Stacy, Pineville

Bruce Underwood, Louisville

I offer this resolution.

SPEAKER HOUSTON: The Speaker will refer that to Reference Committee No. 2, at which time it will be discussed and then we will come back for action at the second House of Delegates.

We will now hear the report of the Medico-Legal Committee, Dr. J. B. Lukins of Louisville, Kentucky.

REPORT OF THE MEDICO-LEGAL COMMITTEE TO THE 1952 SESSION OF HOUSE OF DELEGATES

During the past year the work of the Medico-Legal Committee has been varied and rather interesting. In comparison, we have had a rather light year. It is easy to remember when about 75% of the cases were from bad results in the treatment of fracture. We are proud to report that during this year, we have only had two fracture cases. The number of cases from burns from fluoroscope, violet ray, etc., has increased.

We would emphasize again that the medical schools place more emphasis on the teaching of the technical use of X-ray.

During the year, we have had a demonstration of the lowest form of medical ethics prompted by jealousy and envy of a neighbor doctor, which we have ever seen. Practically every doctor in the county and our valuable councilor, and 2 or 3 others from surrounding counties, came to the rescue of the defendant and when the day came for trial, the accuser's office was locked and deserted, and as far as we know, he has not been seen in the state since. The jury gave a unanimous verdict in favor of the defendant.

We have now 9 cases in our file that are yet to be disposed of. Two of these are more than two years old and in all probability will never come to trial. Only 2 suits have been filed this year. Five cases have been compromised by the insurance companies for small amounts. Three of these were for very small amounts. We have not lost a case by trial this year.

We would like to ask again that the doctor report promptly when a case is threatened. With frank and complete cooperation we can usually change the entire situation. If we do not get the real facts promptly, we can do very little. I sometimes think that if, by some magic, professional jealousy could be entirely eliminated, it would do away with all mal-practice suits.

We express our appreciation to the doctors in the state who have given us a helping hand in all the cases that were tried. Without medical testimony, the plaintiff can do little. We would emphasize promptness in reporting and complete cooperation in every case where there is any serious dissatisfaction.

"An ounce of prevention is worth a pound of cure."

Respectfully submitted,

MEDICO-LEGAL COMMITTEE

/s/ J. B. Lukins

J. B. Lukins, Louisville, Chairman

Clark Bailey, Harlan

Lanier Lukins, Louisville

Bruce Underwood, Louisville

Woodford B. Troutman, Louisville

SPEAKER HOUSTON: His report has been received and it will be referred to Reference Committee No. 2 for study.

We are ready for the reports of the special committees. The report of the Kentucky Committee for Contributions to the American Medical Education Foundation, Dr. Hancock.

DR. HANCOCK: Mr. Speaker, the report has been filed.

REPORT OF KENTUCKY COMMITTEE FOR CONTRIBUTIONS TO THE AMERICAN MEDICAL EDUCATION FOUNDATION TO THE

1952 SESSION OF HOUSE OF DELEGATES

After the last meeting of the House of Delegates of the Kentucky State Medical Association the Council felt that the society was not financially able to make a contribution to the Foundation.

Later, when the Chairman of this Committee was appointed, he had considerable difficulty in securing members to serve on the Committee. This lack of interest led to a postponement of any active drive for funds early in the year. Another reason for deferring solicitation was the marked drop in A.M.A. membership in Kentucky. This had resulted in the loss of one delegate to the A.M.A. A restoration of membership which entailed negotiation regarding delinquent dues in many instances, seemed to the Chairman to take precedence over a drive for solicitation to the Education Foundation. Ample time has now elapsed and a year-end effort is being planned.

Contributions by Kentucky physicians to the University of Louisville Alumni Fund are considered as a part of our aid to the American Medical Education Foundation. So far this year \$3,059.00 has been raised through this medium. In addition, other contributions have been made privately and directly through the Foundation.

We urge your approval of this drive for funds. It is our only effective answer to and weapon against Federal contributions which will inevitably mean Federal control of medical education. You are reminded too that you may designate any school in any state to be the recipient of your contribution.

A supplementary detailed report by the entire committee will be offered to the State Journal for publication.

Respectfully submitted,

KENTUCKY COMMITTEE FOR CONTRIBUTIONS TO THE AMERICAN MEDICAL EDUCATION FOUNDATION

/s/ J. Duffy Hancock

J. Duffy Hancock, Louisville,

Chairman

Howell J. Davis, Owensboro
J. Gant Gaither, Hopkinsville
Charles F. Long, Elizabethtown
M. J. Henry, Louisville
Sam A. Overstreet, Louisville
Winfrey P. Blackburn, Frankfort
Harold Parker, Maysville
William H. Pennington, Lexington
Edward H. Ray, Lexington
Wendell V. Lyon, Ashland

SPEAKER HOUSTON: It has been received and I am referring it to Reference Committee No. 3 for study and recommendations.

The Diabetes Committee, Dr. Carlisle Morse of Louisville.

DR. MORSE: The report has been filed.

REPORT OF DIABETES COMMITTEE TO THE

1952 SESSION OF HOUSE OF DELEGATES

The work of your Committee has been twofold:

Diabetes Detection and Education. Within the past year the American Diabetes Association has changed its Committee on Diabetes Detection to the Committee on Detection and Education. We feel that everyone cooperating with our Committee has rendered an excellent service to the people of Kentucky and honored the profession in a traditional way.

In the Diabetes Detection Drive, November 11-17, 1951, there were 11,136 urine sugars done, 222 found positive, and 74 proved to have diabetes. There were 65 County Diabetes Committees appointed, and 32 of them participated and sent in reports. The drive was endorsed by the Kentucky Pharmaceutical Association, Kentucky State Dental Association, Kentucky Hospital Association, Kentucky State Society of Medical Technologists, Kentucky Chamber of Commerce, Kentucky Farm Bureau Association and Kentucky Congress of Parents and Teachers. The Kentucky State Medical Association got more newspaper reporting in column inches in the drive than for any other one thing it ever did, except for the Centennial. We believe the people of Kentucky are a bit more diabetes conscious. We sincerely appreciate the support of these endorsing organizations and are extremely grateful to the radio stations and newspapers who gave the drive such excellent publicity.

Since the drive was organized on the county level, the major portion of the credit must be given to the committees that organized the drive in their counties. The Christian County Committee, with James R. Dade, M. D., as Chairman, is to be commended for outstanding work in their county, running 3075 urine sugars.

And since this is one health drive that has been kept in the hands of the doctor himself,

it is cheering to see the great number of doctors who recognize this, and have been very helpful in promoting the drive. We are very grateful to the laboratories, hospitals and every one helping in the drive.

On April 10, 1952, John A. Reed, M. D., Chairman of the Committee on Detection and Education, American Diabetes Association, and Mr. J. Richard Connelly, Executive Director of A.D.A. flew over to Louisville to attend a meeting of our committee. They were a great help and inspiration to your committee.

The Chairman of your committee has been appointed to the Committee on Detection and Education of the American Diabetes Association, and by request appeared on a panel before an open meeting of the committee in Chicago, June 9, 1952.

Your committee has been fortunate to obtain Arthur R. Colwell, M. D., Chairman, Department of Medicine, Northwestern University, and the immediate past president of the American Diabetes Association, to appear on the program of the Kentucky State Medical Association in October, 1952. Also, we have been glad to help arrange for a diabetes edition of the Journal of K.S.M.A. for October, 1952.

At present we are organizing for the Diabetes Detection Drive for November 16-22, 1952. This will, as before, be organized on the county level, with your committee and the Committee on Detection and Education of the American Diabetes Association helping in every way possible. We are hoping for greater results this year.

The Ames Company of Elkhart, Indiana, donated Clinitest tablets throughout the state for the urine sugar tests, and we extend to them our greatest appreciation.

Your committee could not have carried on had it not been for the able assistance and inspiration given by Mr. Joseph P. Sanford, Executive Secretary, and Mr. Raymond Jones, Field Secretary. And none of us could have gotten along without the efficient and hard-working young ladies of the Headquarters Office.

We have enjoyed and are deeply grateful for the excellent support given us by our President, Clark Bailey, M. D., and our Councilors.

Respectfully submitted,

DIABETES COMMITTEE

/s/ Carlisle Morse

Carlisle Morse, Louisville, Chr'm.

George N. Burger, Covington

William P. Hall, Paducah

Frank H. Moore, Bowling Green

Herald K. Bailey, Ashland

Franklin B. Moosnick, Lexington

Luther Bach, Lexington

W. R. Parks, Harlan

Gunn S. Cost, Hopkinsville

SPEAKER HOUSTON: Report is in. It is being referred to Reference Committee No. 3.

We are ready for the report of the Advisory Committee to the Editor, Dr. Guy Aud.

DR. AUD: The report has been submitted.

REPORT OF ADVISORY COMMITTEE TO THE EDITOR TO THE 1952 SESSION OF HOUSE OF DELEGATES

It has been the policy of the Advisory Committee to the Editor to move slowly and cautiously in making recommendations to him for radical change in the format and subject matter of the Journal. Only in retrospect can one appreciate the many changes that our Journal has undergone within the past few years. We like to believe, as we are so frequently told by great numbers of subscribers, that such changes have added greatly to the attractiveness of the Journal and to the improvement of its scientific content.

During the past year it has been necessary to add several names to the Board of Editorial Consultants in order to more adequately cover the various fields of medicine and to relieve the work that has been put upon consultants in certain other fields, such as medicine and surgery. The Committee wishes to take this opportunity of expressing its appreciation of the fine, unselfish work of all of the consultants.

The Committee is pleased with the reception with which the new departments of the Journal have been received and trusts that future changes will be as well received. We hope your interest in our Journal will continue and grow. We particularly appreciate the cooperation of the Council of the Association in aiding us in every way possible to improve the Journal.

Respectfully submitted,

ADVISORY COMMITTEE TO
THE EDITOR

/s/ Guy Aud

Guy Aud, Louisville, Chairman

Richard J. Rust, Newport

James E. Hix, Owensboro

SPEAKER HOUSTON: That report is referred to Reference Committee No. 3.

The Education Campaign Committee, Dr. Pierce of Covington.

DR. PIERCE: Mr. Speaker, members of the House of Delegates, the report has been filed, and is in your envelope. I had a remark or two that I wished to make in connection with that. As you will notice, if you have had a chance to look over that, there are quite a number of projects which we have undertaken to start during 'he past year. We are happy that some of these have gotten well under way. Others we hope to see carried on to further progress during the coming months. One thing that has prevented us from making more rapid progress

has been the fact that our field secretary was very much occupied during a good portion of the year with the Legislature, and in connection with certain legislative matters. Also, we regret to state that a few months ago our field secretary felt that he wished to return to his previous work of school teaching and interrupted his work in association with the work of our committee. I am very happy to report that we have engaged the services recently of a new field secretary, a man that has quite a lot of experience in this work. With his able help, we expect to carry on the program that we have started, and I am sure that all of you will have opportunity in the next few months to get acquainted with Mr. Miller, our new field secretary. I wish to express on behalf of our committee the deep appreciation of Mr. Sanford's work he did in getting the work started and also the Chairman of the Committee who so very enthusiastically helped us get started on our program.

REPORT OF EDUCATION CAMPAIGN COMMITTEE TO THE 1952 SESSION OF HOUSE OF DELEGATES

While the full personnel of this Committee was not announced by the Council until the summer began, two meetings have been held, some projects are already under way and others are still in the process of being developed. To our first meeting were invited Clark Bailey, M. D., Harlan, President of the Association, and Larry Rember, Field Director, Department of Public Relations of the American Medical Association. The presence of these men contributed much to the meeting and we are grateful for their assistance.

The first project sponsored by the Committee was an exhibit at the Annual Meeting of the Kentucky Education Association. Exhibit material for the booth was borrowed from the Bureau of Health Education of the American Medical Association, which was built specifically for meetings of this sort. Most of the 6000 people who registered at the K.E.A. saw our booth, which was manned by Mr. Raymond Jones, who was serving as the Field Secretary at that time. Title of the booth, which elicited much interest, was "Examining the School Child." One-hundred fifty-seven health and gym teachers registered for the various school health aids, which were sent them by the A.M.A. The Committee felt this was a very worthwhile project.

The Committee feels that, since one of its purposes is a long range program of education, it should continue the practice of issuing a newsletter. The first issue of this publication has already gone out to the members. It will be mailed quarterly, for the time being, and will be enclosed with the Secretary's Letter.

The Committee, through the issuance of this letter, will carry material and news that will be both informational and inspirational and which would not have appeared in other Association publications. Any suggestions the members may have as to how our newsletter may be used will certainly be appreciated.

Another project of the Committee, which we believe had a very favorable impact upon the public, was the 1952 exhibit in the Merchants' and Manufacturers' Building at the Kentucky State Fair. One of the members of our Committee, George Brockman, M. D., Greenville, designed and built this most interesting display. The booth graphically showed the thousands that passed it each day and the small percentage of their income that actually was spent on medical care. Using an electrically operated device and a system of lights, the pie-shaped diagram vividly called to the attention of the viewer the relationship between his spending for medical care, alcoholic beverages, recreation and cosmetics. The Committee is indebted to Dr. Brockman for his deep interest and his willingness to build and show this very effective exhibit.

It has been planned that our exhibit at the Fair would be manned by Mr. Raymond Jones, Field Secretary, but since the call to return to his first love, the teaching profession, became too strong, we had to make other plans. (Mr. Jones left the Association on September 1). The Committee employed a woman through the Louisville Chamber of Commerce who, under the circumstances, did a very good piece of work. As an attention-getting device, all comers were weighed free of charge. While in the booth, they were given the beautifully designed and very effective A.M.A. booklet entitled "Your Money's Worth in Health," a publication which was very appropriate and which complemented the information given at the exhibit.

Our Committee feels that the importance of young doctors becoming interested in the affairs of the profession at the earliest possible date cannot be over-emphasized. It believes that when these men become acquainted with what organized medicine is doing, they will want to support it. So, at the request of the Committee, the Executive Secretary, Mr. J. P. Sanford, has spoken to each of the new classes at the University of Louisville School of Medicine and urged them to attend our meetings and to visit the scientific and technical exhibits. He also urged them to become members of the Student K.S.M.A. In addition, all interns and residents in Kentucky hospitals received a program leaflet and a letter urging them to attend this meeting. We hope all of you will make every effort to welcome the students and interns (which you will be able to

distinguish by the badge they wear) and make them feel at home at this meeting.

Since in the end, the opinion the patient forms of his doctor is based primarily on the way the doctor conducts himself in the presence of the patient, and since the way the public regards the profession is based on the sum total of these individual opinions, the Committee has spent a very considerable amount of time in the consideration of this matter. While other approaches are in the process of being determined, the Committee feels that serious and favorable consideration should be given by the faculty at the University of Louisville School of Medicine to including in its course of study during the senior year, a subject that might be called "Medical Manners and Public Service." Other schools have added courses of this sort and found them highly profitable. The Committee has authorized one of its members to take this matter up with the Dean of the Medical School.

Plans for the establishment of a course for the training of physicians assistants were well under way at the time of Mr. Jones' resignation. Further implementation of this program will have to wait until a new Field Secretary is employed and orientated. This idea is relatively new, the Tennessee State Medical Association being the only organization to undertake an activity of this sort that we know of. The purpose of the course is to help the assistants improve their service to the physician in the field of filling out insurance papers, answering the phone, dealing with the patients, assisting in the operation of the office and other matters of this type. It is planned that the course will be held for one hour each month for three months. Blue Cross-Blue Shield officials and representatives of insurance companies would help in the instructions on completing insurance papers. The course would be cleared through and sponsored by the members of the County Medical Society.

Prior to Mr. Jones' resignation, and at the request of the Committee, he contacted a number of the small radio stations in the state, the purpose being to arrange, in behalf of the local county medical society, transcribed radio programs which are produced by the A.M.A. Bureau of Health Education and designed for this use. Sometimes these programs are commercially sponsored, others are used on "Public Service" time. In the short period of time this effort was undertaken, much interest was manifested. At the same time, Mr. Jones contacted the local newspapers as a matter of good will, and in addition offered them the A.M.A. weekly news release and "filler material." Mr.

Jones reported that this idea was also well received. Further implementation of this important program will have to await the employing of another Field Secretary.

One of the most potent criticisms of the medical profession—certainly one that is among the most discussed in lay circles—is the failure of the patient to get a physician in an emergency, particularly on Sundays, afternoons off and holidays. The Committee is studying means of promoting the acceptance and implementation of the Emergency Call Bureau plan in the various county medical societies. Kentucky is far behind many of the states in this respect. The development of this program will also have to await the employment of a Field Secretary. In the meantime, the Committee warmly urges each County Medical Society that does not have an Emergency Call System to consider forming one at the earliest possible date. The Committee, through the Headquarters Office, will give you every possible assistance. In addition, the Committee urges each physician who has to leave the community to arrange for his practice to be covered at all times while he is away. When the physician accepts the care of the patient and when well patients depend upon him, it is his definite and inescapable responsibility to make certain their needs are arranged for during his absence.

The Committee would like specifically to recommend to this House of Delegates that county medical societies establish a press-radio-medical code of relations at the county level. It is recognized that on one hand the physicians and hospitals and, on the other, news gathering agents of the press and radio, on occasion are at fault in misinformation the public receives. A small amount of time invested by the County Medical Societies in this direction, our committee is confident will pay big dividends in improved information to the public and in relationships with the press, radio and public. It will also contribute to a better understanding of the problems each group must deal with. The Committee has county press-radio-medical codes that have been successfully used elsewhere, and it will be glad to assist any society that is interested in undertaking this vital matter.

If the Chairman of the Committee may be granted the privilege of expressing a personal opinion, he would like to state he has been given an excellent group of men to work with on this committee. They are deeply conscious of the problems this Committee has been asked to deal with and eager to do something about them. They have been both loyal and active in their support of this work. Your Chairman

is very glad for the opportunity to work with the members of this Committee.

Respectfully submitted,

EDUCATION CAMPAIGN COMMITTEE

/s/Vinson Pierce

W. Vinson Pierce, Covington,
Chairman

George F. Brockman, Greenville
Richard G. Elliott, Lexington
Wendell V. Lyon, Ashland
George William Pedigo, Louisville
Charles Stacy, Pineville

SPEAKER HOUSTON: That report is referred to Reference Committee No. 3.

We are ready for the report of the Emergency Medical Service Committee, Dr. Graves, Bowling Green. Dr. Graves.

REPORT OF COMMITTEE ON EMERGENCY SERVICE TO THE

1952 SESSION OF HOUSE OF DELEGATES

DR. GRAVES: Mr. Speaker, members of the House of Delegates, Governor Lawrence Wetherby asked our President, Clark Bailey, of Harlan, for the cooperation of the medical profession in setting up a Civil Defense Organization early this year. On behalf of the association, Dr. Bailey immediately pledged the support of the profession and referred the Governor's request to the Committee on Emergency Medical Services of the Association.

A meeting of our committee was called at once. At this first session two officials from the Federal Civil Defense Organization in Washington, one from the Regional Organization in Cleveland, along with General Lindsay, State Civil Defense Director and P. M. Crawford, M. D., Deputy Director of Medical Services for the State, were present. In addition a representative of the A.M.A. Council on Emergency Medical Services attended, as did President Clark Bailey.

General Lindsay, the State Civil Defense Director, at this first meeting requested the formation of four Mobile Defense Units, composed of twenty-five doctors, located at Louisville, Paducah, Ashland, and Bowling Green. While Lexington was included in the Ashland District as set up by General Lindsay, the profession at Lexington has very generously agreed to form a Medical Unit of its own and has recruited specialist teams. Louisville has formed two units; Paducah, Bowling Green and Ashland have formed one each. These are to be temporarily assigned to any disaster area in the state until it is able to look after its own casualties. In addition, ten general practitioners in each area, except Louisville, (20 there), have been recruited for aid work.

At the suggestion of Dr. Bailey, who has

met with us on several occasions and who has cooperated beautifully with this committee, General Lindsay has authorized the formation of another Medical Unit in the Harlan area.

The Medical Profession in Louisville is to be commended for setting up its program for Civil Defense. Our committee has been told by responsible sources, and the evidence substantiates the statements, that the Medical Profession in Louisville has accomplished all it will be able to do until associated services in the Civil Defense effort there have made similar progress.

We have asked the staffs of the hospitals of the state to study their bed capacities, their personnel, and their resources so that in case of disaster it would be possible to expand their capacity two or three times; to train additional nurses, aids, technicians; to have a disaster plan to take care of any emergency; to organize emergency hospitals. The response to our plea has not been all that could be desired in most instances. The Louisville area has its hospitals fairly well organized and certain schools designated as auxiliary hospitals.

The Governor and General Lindsay were interviewed about supplies. We are informed that there is only \$40,000.00 available to purchase medical supplies for the Civil Defense effort and this money is all earmarked for Louisville—since the city of Louisville appropriated \$10,000.00 of this amount, which was matched by the state, and that in turn matched by the Federal Government. Even to a casual observer it becomes immediately apparent that an amount far in excess of this figure is indicated if the job is to be done. The Federal Civil Defense authorities feel that to care for a thousand and casualties would cost about \$21,000. Tennessee has available \$1,750,000.00 for implementing the Civil Defense Program in that State. In case of disaster we would be very hard put to take care of the casualties. It was pointed out that the doctors without supplies or skilled aid in the auxiliary services would be of little use. We believe we cannot stress too strongly the need of equipment and supplies; also the need of good organization and training of the auxiliary services. We were told that the Federal Government would probably locate a medical supply depot in Kentucky. The State Medical Association was asked by the Governor in a letter to President Clark Bailey to assume responsibility for the organization for Civil Defense. Doctor Bailey accepted this responsibility but it should be pointed out, no responsibility for medical supplies was requested of the State Medical Profession by the government. The Medical Profession cannot and should not be expected to assume the responsibility of the vast quantities of medical supplies required for this task.

Our committee has given a great amount of consideration to supplying needed blood in case of a disaster. At the present time we have not perfected a satisfactory plan. We have one of our committee members assigned especially to this problem, and he is exploring the various possibilities.

The training program for the treatment of atomic illnesses is going forward slowly. The program has been carried out in six of the twenty second and third class cities and four others have promised to give it this fall. We hope to give it in the remaining ten cities this fall and winter.

Each county society and hospital will be asked to appoint a Civil Defense Committee to set up its local Civil Defense plan; to decide upon what doctors it can supply to Civil Defense for temporary use in case of disaster in other communities of the state and the use of its own physicians and hospitals to take care of casualties from the disaster area.

Governor Wetherby has demonstrated a sincere interest in setting up an adequate Civil Defense Organization in this state. He has met with representatives of the association and discussed with us in a frank and open manner the problem we face.

Our committee has held four half-day meetings with excellent attendance. Each member of the committee has accepted a definite assignment and all are giving their best efforts. These assignments are:

Thomas V. Gudex, M. D., in charge of the Organization and the Mobile Defense Units in Louisville.

Leon Higdon, M. D., the Organization and in charge of the Mobile Defense Unit in Paducah.

John S. Sprague, M. D., the Organization and command of the Mobile Defense Units in Lexington.

Leland Payton, M. D., Lynch, Kentucky, Disaster Plans for Hospitals.

Dr. W. Mountjoy Savage, Maysville, The Blood Program.

As chairman of the Committee I feel that I have been most fortunate in being associated with these hard-working, patriotic physicians who are doing such excellent work and who are giving so generously of their time in this important work. I sincerely appreciate their wholehearted support and cooperation.

The committee wants to acknowledge the excellent assistance and support of Dr. Crawford, State Deputy Director of Health Services. Dr. Crawford has made himself available at all times and has attended all of our committee meetings, and is in constant touch with its work. We value his judgment highly and appreciate his cooperation. We also appreciate the work of Mr. Joe Sanford and Mr. Jones of the Headquarters Office. They have been in-

valuable in arranging meeting places and in helping the program to move smoothly.

At this stage in world development the subject of Civil Defense is not being taken as seriously as it should be in the medical profession, specifically, or the public generally. Yet if one carefully reviews the situation, it becomes obvious that the threat is very serious. In case of atomic disaster, the medical profession will have a tremendous responsibility. The physicians of Kentucky have always been among the first in discharging their obligations. Your committee needs and earnestly solicits the support of every member of the association as it moves ahead with this important problem.

Respectfully submitted,

**COMMITTEE ON EMERGENCY
MEDICAL SERVICES**

/s/ G. Y. Graves

G. Y. Graves, Bowling Green,
Chairman

Thomas V. Gudex, Louisville

Orion L. Higdon, Paducah

Leland E. Payton, Lynch

W. Mountjoy Savage, Maysville

John S. Sprague, Lexington

SPEAKER HOUSTON: Dr. Graves' report will be referred to Reference Committee No. 3. We are now ready for the report from the Committee on Hospitals, Dr. Flowers of Middlesboro. Dr. Flowers.

**REPORT OF COMMITTEE ON HOSPITALS
TO THE**

1952 SESSION OF HOUSE OF DELEGATES

The Committee on Hospitals of the Kentucky State Medical Association has not had a formal meeting during this calendar year, there having been no matters brought to the attention of the Committee which demanded a meeting. However, it is recommended that this Committee consider the UMWA Hospitalization program as outlined for Eastern Kentucky at some time during this winter, and look very carefully into the program which this organization proposes to put into operation in our State, as it may affect the patients served and, also, the physicians who are already serving the area to be covered by this UMWA Program.

Respectfully submitted,

COMMITTEE ON HOSPITALS

/s/ S. H. Flowers

S. H. Flowers, Middlesboro,
Chairman

Charles B. Johnson, Russell

John P. Glenn, Russellville

E. S. Dunham, Edmonton

Joseph C. Bell, Louisville

B. Earl Caywood, Danville

Rankin C. Blount, Lexington

SPEAKER HOUSTON: Dr. Flowers' report is in. Its been referred to Reference Committee No. 3.

We are ready for the report of the Kentucky Advisory Committee to Selective Service System, Dr. A. Clayton McCarty of Louisville.

**REPORT OF THE KENTUCKY ADVISORY
COMMITTEE TO SELECTIVE SERVICE
SYSTEM TO THE
1952 SESSION OF HOUSE OF DELEGATES**

During the past year this committee has carried on its functions in a somewhat normal manner, continuing to make more enemies than friends, I am sure, in spite of efforts to please all. Essential individuals have been preserved for the home front, while an adequate supply of medical personnel has been furnished to the armed forces.

Our greatest problem has been getting cooperation from the Navy. On more than one occasion, recommendations have been made following a careful study of individual problems. In every case the conclusions of the Kentucky committee have been confirmed by the National Committee and other interested organizations, but more than once the Navy Board of Personnel has reversed all opinions and called men into service who should be here in Kentucky carrying on essential jobs. This has been drawn to the attention of the National Advisory Committee in no uncertain terms. Several times the Kentucky committee has been at the point of resigning in toto. Feeling that this might work a hardship upon the Kentucky doctors being considered, the committee has continued to function; but we feel that any further failure to cooperate in Washington will lead to a discontinuing of furnishing information and making recommendations to the Navy, at least.

We have continued to have difficulty with fiscal matters, but these were usually adjusted in the end and is what one is to expect when dealing with government agencies. Your committee is rather unhappy because certain Selective Service Boards have placed doctors in a II-A or deferred category when there is every reason to feel that these men should be in service. They represent Priority I and II men who have been deferred mainly through political influence. (These are the physicians who were given their medical education by the government or excused from service to complete said education.)

At the present time, much thought and attention is being given to the Priority III physicians. (These are the men who have had no military service since September 1940.) There is much pressure from many quarters to have a large number of these doctors placed in military service. The problem is not a simple one,

however, since a large proportion of this group is in the IV-F category (physically or mentally incapacitated), or are over 36 years of age. Being over 36 and because of other professional qualifications, most of these men are entitled to higher rank, and there are very few vacancies in this grade to be given out. At all events, every effort is being made to keep the military demands supplied with doctors from Priorities I, II, and III; and, later on, graduates, especially non-veterans, from the medical schools and internships. This will spare the Priority IV group, which is composed of veterans who have seen service in one or more wars.

Once again we wish to thank the Councilors and the doctors representing the Advisory Committee for county societies for their splendid cooperation. A few have fallen down on the job, and it has been necessary to secure other helpers in order that we should be properly advised on local situations. For the most part, however, information has been furnished of the most important order and without thought of popularity or lack thereof, which such information would eventuate in. There are some thoughts that Public Law 779 will not be re-enacted when it expires in June 1953. Until that time, however, the Kentucky Advisory Committee will continue to call upon the physicians of the state for advice. It is obvious that we cannot count upon politicians, local pressure groups, and even many Selective Service Boards to provide unbiased opinions.

No report of this kind would be complete without giving some word of commendation to Mr. Joseph P. Sanford, Executive Secretary for the Kentucky Advisory Committee. If and when Mr. Sanford is not available, there likely will be no Kentucky Advisory Committee to Selective Service.

Respectfully submitted,

**KENTUCKY ADVISORY COM-
MITTEE TO SELECTIVE SERV-
ICE SYSTEM**

/s/ A. Clayton McCarty

A. Clayton McCarty, M. D.,
Louisville, Chairman

Charles B. Billington, M. D.,
Paducah

Glenn U. Dorroh, M. D., Lexington
R. Arnold Griswold, M. D.,
Louisville

J. Duffy Hancock, M. D., Louisville
L. O. Toomey, M. D., Bowling
Green

Marcus G. Randall, D. D. S.,
Chairman, Dental Subcommittee,
Louisville

A. B. Coxwell, D. D. S., Louisville
O. B. Coomer, D. D. S., Louisville

F. E. Hull, D. V. M., Lexington,
Chairman, Veterinarian Subcommittee

Lula B. McClain, Louisville,
Chairman Nurses Subcommittee

SPEAKER HOUSTON: That report is being referred to Reference Committee No. 3.

The report of the Dental Committee, Dr. Crume.

REPORT OF K.S.M.A. DENTAL COMMITTEE TO THE 1952 SESSION OF HOUSE OF DELEGATES

One meeting to date of the Kentucky State Medical Association Dental Committee was held Thursday, May 15, 1952. It was gratifyingly attended by all but one of the Committee and also present were J. P. Sanford, Executive Secretary, and R. M. Jones, Field Secretary.

The Committee reviewed the activities of the previous year's Committee and the response of the Association to its suggestions. It was learned that the Council's approval, expressed by letter to the County Medical Society Secretaries, of the principle of the Dentists becoming associate members, had provoked no action by the County Societies.

The matter of the administration of parenteral antibiotics, anesthetic agents and other drugs by Dentists was discussed and it was learned that there were no developments more illuminating than the opinion of Judge L. R. Curtis personally expressed before the previous year's Committee. It was interesting to learn that companies writing malpractice insurance in adjoining states were providing dental coverage for the administration of parenteral antibiotics.

The recommendation of the previous year's Committee regarding an essay contest for the senior students of the Medical and Dental School was abandoned in favor of a plan to ask an outstanding member of the Dental Profession to present a scientific paper at the Kentucky State Medical Association's Annual Meeting.

The Committee, in considering how it could best function to promote better relationships between the Dental Profession and the Medical Profession, decided that a declaration of purpose to be followed in the future was necessary. It further agreed that the proper place to attack this problem was at the county level rather than at the state level. The plan was developed that the Committee would set up a recommended program of action for the County Medical Society to follow. It was felt that once this program was approved by the Executive Committee and the Council, that the next step would be to ask the Liaison Committee of the State Dental Association to meet with the Medi-

cal Association and undertake the implementation of as many planks in the platform as possible.

The Committee then voted to recommend to the Executive Committee a program for consideration by the County Societies, which included the following points:

1. That County Medical Societies and Dentists in the community have at least one joint scientific meeting every year, in which matters of mutual interest would be treated by a competent essayist.
2. That some type of joint meeting (possibly including the wives and families of the physicians and dentists) of a social nature be held once a year.
3. That physicians and dentists in the local community collaborate in the solving of local public health problems.
4. That the dentists be asked to participate in all local Civil Defense plans.
5. That the dentists be asked to participate and cooperate in the Diabetic Detection Drive held each November.
6. That the dentists be asked to support the Rural Health Movement and cooperate with the physicians in sponsoring and providing leadership for such efforts.
7. That physicians and dentists unite their efforts in attempting to get all persons involved in health service, including their own families and employees registered and see that they vote in each election.
8. That the two professions explore areas in which they could cooperate in solving public relations that might exist at the local level.

At the meeting of the Executive Committee of the Council, in session at Lexington on July 17, 1952, these recommendations were accepted and, in turn, recommended that they be approved by the Council and the House of Delegates.

A combined meeting of the comparable Committees of the Kentucky State Medical Association Dental Committee and the Kentucky State Dental Association Medical Committee is anticipated in the near future. A supplementary report will be submitted at a later date regarding any developments materializing at this time.

Respectfully submitted,
K.S.M.A.-DENTAL COMMITTEE
/s/ Thomas J. Crume
Thomas J. Crume, Owensboro,
Chairman
Millard C. Loy, Columbia
Henry V. Johnson, Georgetown
Allen L. Cornish, Lexington
R. Ward Bushart, Fulton

SPEAKER HOUSTON: The report has been filed with the Secretary and referred to Reference Committee No. 3 for study.

The report of the Pharmacy Committee, Dr. Hollis of Louisville.

**REPORT OF K.S.M.A. PHARMACY
COMMITTEE TO THE
1952 SESSION OF HOUSE OF DELEGATES**

There was no business referred to the Pharmacy Committee this year. There was no business that required the calling of a meeting of the Committee.

It is recommended that the Committee continue to be organized and meet with the Pharmacists next year,

Respectfully submitted,
K.S.M.A. PHARMACY COM-
MITTEE

/s/ Ben H. Hollis

Ben H. Hollis, Louisville, Chairman
Thornton Scott, Lexington
W. Keith Crume, Bardstown
Hugh L. Houston, Murray
Thomas P. Leonard, Frankfort

SPEAKER HOUSTON: Dr. Hollis is not here. His report is in. It is being referred to Reference Committee No. 3.

The Legislative Committee report will be made by Dr. Baughman of Frankfort. Dr. Baughman.

DR. BAUGHMAN: Mr. Speaker, members of the House of Delegates, the report of the Legislative Committee was written in Frankfort last winter. Thanks in great part to a loyal, friendly Governor, and his administration, he gave us his unswerving and constant support. It was also written in part by the interest in health of you men here and the other doctors in the State of Kentucky. For the record, we have filed a written report of the Legislative Committee which is in your hands and in the hands of the Secretary. I wish to add only a few words to this report.

No. 1, I would like to urge for the Committee that every doctor vote for somebody on November 4th. No. 2, that you inform yourself on how the candidate of your choice feels about the issues in which medicine is concerned. In some instances, we have urged certain county societies to find out by questionnaire how the candidates for Congress feel about the questions in which we are interested. There are other ways in which you can find out. Personally and individually, if you do not know, you can ask a man whom you wish to support.

Next, I would like to urge that you let the candidate of your choice know how you feel about these issues. Furthermore, I would like to urge that you not all vote for the same can-

didate. Many a horse race has been won by dark horses, and we would like to have the winner feel that he has friends among the medical profession in Kentucky. Again we appreciate the interest and support of the doctors of Kentucky, and we urge you to continue that interest.

**REPORT OF LEGISLATIVE COMMITTEE
TO THE
1952 SESSION OF HOUSE OF DELEGATES**

The primary concern of the Legislative Committee during the past year was with the action of the regular 1952 Session of the Kentucky General Assembly. The Association sponsored no legislation at that session but gave active support to several bills sponsored by the Department of Health. Measures in that category, of the greatest interest to members of the Association, which were enacted into law included the following:

House Bill No. 137, known as the "Medical Practice Act," which is a comprehensive revision of the law regulating the practice of medicine and osteopathy.

Senate Bill No. 50, referred to as the "Hospital Licensure Bill," which provided for the licensing and inspection of hospitals.

House Bill No. 280, a professional titles act, which restricts the use of the title "Doctor," in connection with the practice of the healing arts, to persons holding degrees from authorized institutions and requires the designation of the particular degrees held by such persons.

Senate Bill No. 115, which permits the payment of salaries of physicians employed by State institutions in amounts not to exceed \$12,000 annually, thus removing the previous limit of \$7,000.

Senate Bill No. 140 created a new and separate Department of Mental Health.

House Bill No. 144 authorizes the State Board of Health to render technical assistance to local health departments and established a broad formula for the allocation of state funds to such units upon an equalization basis.

An unsuccessful attempt was made to amend the Hospital Licensure Bill so as to exempt chiropractic hospitals.

During the period before and during the Legislative Session, the Committee held numerous meetings and served as a clearing house for legislative matters.

As a result of the year's work, this Committee is convinced that the success or failure of the Legislative Committee depends entirely upon the extent to which each individual member of the Association informs himself upon governmental affairs, particularly on the local

level, and his participation in the election of qualified and honest public officials.

Respectfully submitted,
LEGISLATIVE COMMITTEE
 /s/ Hugh L. Houston
 Hugh L. Houston, Murray, Chairman
 /s/ B. B. Baughman
 Branham B. Baughman, Frankfort,
 Co-Chairman
 Rufus C. Alley, Lexington
 Guy Aud, Louisville
 Clark Bailey, Harlan
 R. Haynes Barr, Owensboro
 Clyde C. Sparks, Ashland
 Charles B. Stacy, Pineville
 Charles B. Wathen, Owensboro
 Billy K. Keller, Louisville
 Norman Adair, Covington

SPEAKER HOUSTON: That report will be referred to Reference Committee No. 3.

We are ready for the report of the Directors of the McDowell Memorial Foundation. Dr. Vance.

DR. VANCE: Mr. Speaker, and gentlemen of the House of Delegates. I do not wish to read this report in its entirety, but I would like to tell you that we have \$19,000.00 worth of antique furniture in the house, and it is a beautiful sight over there and I hope you all will go to see it, and I hope you all will read this report. In the end, I say this, this property belongs to the State Medical Association, and we feel the Association should help us in its upkeep, so we would respectfully ask that the House of Delegates of the Association continue the donation of \$1500 for the repairs and supplies of this home, as they have done this year. With all of the expense that we have had this year, we surely could not have gotten along without it and we appreciate the help more than we can tell you. Thank you.

REPORT OF THE BOARD OF DIRECTORS OF McDOWELL MEMORIAL FOUNDATION TO THE 1952 SESSION OF HOUSE OF DELEGATES

We reported in the 1951 report that the McDowell Foundation was incorporated and a considerable amount in donations had been received. These were in the form of memberships in the Foundation for one year at \$2.00; 15 years at \$25.00 and life membership at \$100.00. Last year we had a custodian, Miss Annabel Tompkins, and we have continued her services this year. Last year we charged thirty-five cents each for tourists and this year we charged fifty cents. We have not had very many tourists. A considerable amount of furniture has been bought and placed in the Home and, of course, some has been donated. This

has all been approved by the Furniture Committee consisting of Mrs. W. O. Bullock, Chairman; Mrs. Nelson, Mrs. Goddard and Mrs. Evans, and we have insured all of this antique furniture, and other items, with a Fine Arts Policy and we probably have near \$19,000.00 worth of furniture and articles in the Home and it is insured for about \$16,000.00.

The Woman's Auxiliary of the Fayette County Medical Society has almost furnished their room, and the Woman's Auxiliary of the Jefferson County Medical Society has most of their room furnished. These two Medical Societies have donated probably enough to furnish those two rooms, and the Jane Crawford room is about furnished too: the Colonial Dames keep that room up and insure the contents, but we painted the inside of the room and repaired the window at the expense of about \$75.00.

The House of Delegates and the Council of the Kentucky State Medical Association gave the Board of Directors of the Foundation \$1500.00 for the upkeep and repairs of the Home. So much has had to be done this year that we have not been able to pay for all the needed repairs and supplies. For instance, the expense of a custodian, the painting of the house and the repairs due to the flooding of the cellar and furnace, the stones in the garden, and other necessary things, have cost more than we had to spend.

We had planned to have an exhibit at the American Medical Association meeting in Chicago, but, due to a mixup in sending the necessary exhibit, it was not at all successful.

In the Auditor's account as of June 30, 1952, we had a balance of \$1,424.70 but most of that is in designated accounts for distribution only for those accounts, and we have a balance of \$33.05 in the Supplies and Repairs Account. If we are able to postpone the payment of some of these bills which should be paid we will be able to take care of them from the donation from the Kentucky State Medical Association next year for the upkeep and repairs of the Home. We thought last year that we could get the Home entirely furnished by the end of this year but it has not been possible to do so. There are a number of things which we could use in furnishing the Home but we have made great progress this year and hope to do better next year. The Little Garden Club of Danville, the membership of which is composed of the young ladies of Danville, still takes care of the garden at the Home and we feel that they have done a splendid job, and we are very much indebted to them for their services and donations, and we wish to send them much appreciation and many thanks.

We thought last year at the Kentucky State Medical Association meeting, Louisville, that

the pictures of Dr. Ephraim McDowell, shown at the night session, were very well done and very interesting to the membership, and we are sure that the members of the Kentucky State Medical Association and the Woman's Auxiliary are very thankful to Mrs. Clark Bailey and her Committee. They were very interesting and very much appreciated.

Much more consideration has been given to the Apothecary Shop. We have been worried about this and what to do with it for a number of years, and we have listened to suggestions about tearing down the back end of it, leaving the front third, and we have also listened to suggestions about tearing down the whole house and building a fence in front and continue the brick wall along the west and north side of the property and filling in this cellar and opening an arch in the brick wall that runs into the west wall of the kitchen, making this a part of the garden. Some of our friends have told us that some of the drug houses would pay for this, but we certainly do not have any money ourselves to make these changes. Although, this Apothecary Shop was built by Dr. Ephraim McDowell and used by him and was, also, the second or third Post Office in the State, some of us have begun to believe that the best thing would be to tear it down and make the changes suggested above, but others of our membership are horrified that we would tear down anything that belonged to Doctor McDowell, but it does seem to some of us that the better plan would be to tear it down, as suggested above, and protect the Home in every way that we could. Your Chairman tries not to take any sides in this argument, but it has seemed to me that the latter course is preferred, as the place is ready to fall down now and it would cost from \$3,000.00 to \$5,000.00 to rehabilitate it all, even tearing down the back end of it.

At the last meeting of the Kentucky Surgical Society the McDowell Foundation was discussed thoroughly and this Society is very much interested in the Home and keeping it up, and will make a donation for that purpose each year, and they appointed a committee to confer with the committee of the Kentucky State Medical Association, and the Council has considered several propositions to raise money for it. Of course, the State Medical Association Committee and the McDowell Foundation would be pleased to allow the Kentucky Surgical Society to help in any way they could and we are very appreciative of anything they can do for the McDowell Foundation.

The Board of Directors of the McDowell Foundation still believe that, eventually, the Memorial will become a paying proposition and we hope it will be self-supporting. We know the Woman's Auxiliary will continue in their

work until the Home is completely furnished and perhaps supporting itself. We thank the Woman's Auxiliary Committee for the splendid job and we cannot compliment them and thank them enough for what they have done.

This property belongs to the State Medical Association and we feel that the Association should help us in its up-keep, so we would respectfully ask that the House of Delegates of the Association continue the donation of \$1500.00 for the repairs and supplies of this Home, as they have done this year. With all of the expense that we have had this year we surely could not have gotten along without it and we appreciate the help more than we can tell you.

Respectfully submitted,
BOARD OF DIRECTORS OF THE
MCDOWELL MEMORIAL
FOUNDATION

/s/ Charles A. Vance
Charles A. Vance, Lexington,
Chairman
Russell Starr, Glasgow
E. M. Howard, Harlan
George McClure, Danville
Laman A. Gray, Louisville
Emil Novak, Baltimore, Md.
Thomas Meredith, Harrodsburg
Irvin Abell, Louisville
Orion L. Higdon, Paducah

SPEAKER HOUSTON: The report is being referred to Reference Committee No. 3.

The Committee on Medical Education, Dr. Robert Lich of Louisville.

REPORT OF COMMITTEE ON MEDICAL EDUCATION TO THE 1952 SESSION OF HOUSE OF DELEGATES

The first meeting of the Committee was held November 20, 1951, at the offices of the Kentucky State Medical Association at 7:00 p.m. This meeting was attended by Mr. Joseph Sanford and Mr. Mitchell of the Southern Bell Telephone and Telegraph Company. The subject of Postgraduate Telephone Medical Seminars was discussed. Mr. Mitchell explained the mechanical operations of such a program. It was decided that three monthly programs were to be conducted; one in February, one in March, and one in April, 1952.

The programs were executed and the Committee is indebted to the Southern Bell Telephone and Telegraph Company for their tremendous expenditures of effort to make these programs a success. Also, Mr. Joseph Sanford is due great credit for his assistance to make these programs possible. The Committee wishes to further extend its appreciation to the secretarial staff of the Medical Office of the University of Louisville School of Medicine for the

assistance in preparing the material for distribution to the listening societies.

A total of 26 counties registered for the Seminar Programs and, from the response, the overall picture was excellent.

The Committee would like to express its sincere appreciation to all who participated in the programs and it believes the contributing physicians are to be recognized for truly fine programs on every occasion.

Respectfully submitted,
COMMITTEE ON MEDICAL
EDUCATION

/s/ Robert Lich, Jr.

Robert Lich, Jr., Louisville,
Chairman

D. G. Miller, Jr., Morgantown
Herbert L. Clay, Jr., Louisville
Lawrence T. Minish, Louisville
J. Richard Gott, Louisville

Note: Attached is a copy of the three post-graduate telephone programs.

FIRST POSTGRADUATE TELEPHONE PROGRAM

February 26, 1952

SUBJECT:

Management of the Patient with Jaundice

PANEL MEMBERS:

Walter S. Coe, M. D.

Assistant Professor of Medicine

Marion F. Beard, M. D.

Associate Clinical Professor of Medicine
and Chief of Hematology Section

William M. Christopherson, M. D.

Assistant Professor of Pathology

George B. Sanders, M. D.

Assistant Clinical Professor of Surgery

SECOND POSTGRADUATE TELEPHONE PROGRAM

March 18, 1952

SUBJECT:

Office Gynecology

PANEL MEMBERS:

R. R. Slucher, M. D.

Clinical Associate in Medicine

President of Kentucky Academy of Medicine, General Practice

L. A. Gray, M. D.

Associate Professor of Obstetrics and Gynecology

R. F. Monroe, M. D.

Associate Clinical Professor of Obstetrics
and Gynecology

W. O. Johnson, M. D.

Professor and Chairman of Department of
Obstetrics and Gynecology

THIRD POSTGRADUATE TELEPHONE PROGRAM

April 22, 1952

SUBJECT:

Management of Thyrotoxicosis

Morris Flexner, M. D.

Clinical Professor of Medicine

J. Robert Hendon, M. D.

Assistant Clinical Professor of Medicine and
Lecturer in Therapeutics

Gerald M. Peterson, M. D.

Clinical Instructor in Radiology

R. A. Griswold, M. D.

Professor of Surgery and Chairman of the
Department of Surgery

SPEAKER HOUSTON: His report is in and being referred to Reference Committee No. 3.

The report of the Special Committee on Medical Education, Dr. Sam Overstreet of Louisville.

REPORT OF THE SPECIAL COMMITTEE ON MEDICAL EDUCATION TO THE 1952 SESSION OF HOUSE OF DELEGATES

The Committee on Education wishes to submit the following report: During the year we, individually and as a committee of three, have attempted to keep abreast with the matters of medical education affecting our society. Our efforts have been particularly directed toward the accomplishment of our initial aim: Namely, the expansion of the School of Medicine at the University of Louisville, and, in that, appreciable increase in the number of medical graduates yearly might be obtained.

Repeated conferences with Mayor Farnsley led us to believe that he is earnestly working toward the physical expansion of the Medical School. This is proposed in conjunction with the establishment of the Medical Center, which has for several years been in progress. It is the plan of Mayor Farnsley to recommend a bond issue of one and a half million dollars to be submitted to the citizens of Louisville at the fall election of 1952 for the purpose of erecting and expanding the facilities for the first two years of the School of Medicine. Your committee is arranging means of informing the individual members of the Jefferson County Medical Society of this project and of soliciting their active participation and cooperation with such plans. It is our purpose further to enlist the enthusiastic support of the press and to present the matter before the voters of the City of Louisville in as thorough and intelligent a manner as possible before the bond issue is actually submitted for vote.

We have been keenly interested in developments in connection with the Kentucky State Legislature toward the establishment of a

Medical School at Lexington, Kentucky. Your Council and the Kentucky State Medical Association have expressed their preference emphatically in favor of the expansion of the School at Louisville rather than the establishment of a second school at Lexington. Your committee has no choice other than to endorse and support this opinion.

It seems practical and wise to put constantly before the attention of our profession and citizens, the necessity for expansion of facilities for Medical Education within our state. We propose, therefore, to present from time to time articles bearing upon this subject for publication in the Medical Journal and for general publicity whenever such channels are available.

Your committee feels that the Kentucky State Medical Association is within very reasonable probability of attaining the objective for which we have been working the past two years.

Respectfully submitted,
SPECIAL COMMITTEE ON MEDICAL EDUCATION

/s/ Sam A. Overstreet

Sam A. Overstreet, Louisville,
Chairman

J. Murray Kinsman, Louisville

Bruce Underwood, Louisville

SPEAKER HOUSTON: His report is in. It is being referred to the Reference Committee No. 3.

The Medical Practice Committee, Dr. J. B. Lukins.

REPORT OF THE MEDICAL PRACTICE COMMITTEE TO THE 1952 SESSION OF HOUSE OF DELEGATES

DR. LUKINS: Mr. Speaker, members of the House of Delegates of the Kentucky State Medical Association, I always feel honored when I have the privilege to say something to this body. That is because this is such a splendid organization, and I feel that every Delegate here should feel honored that he was selected by his doctors at home to represent his county here at this organization. No man should take this position lightly. What you do here is serious work. It is important work. It is for the good of the State, and it is possible that the work that you do, the program and plans that you formulate here during this meeting may through the State Board of Health affect every individual in the State of Kentucky.

Now as to this report, it contains nothing sensational. We have solved no problems. I hope in it you will find something interesting, and I also hope that will help eradicate some of the evils of our profession.

In the last twenty years medical practice in Kentucky has undergone a gradual but decided change. Many methods of examination and treatment used by our fathers and grandfathers

have given way to more complete examinations; greater use of laboratory and x-ray facilities making far more accurate diagnosis, and more intelligent treatment. Better roads, more education of the public, public health facilities, and more interest in health and disease in general, have contributed greatly to the longer span of life, which our citizens enjoy.

We have improved ourselves; we are doing a much better job, but there hangs over the profession two threats that are real and possible, of dire consequence.

The first: Compulsory National Health Insurance (Socialized Medicine) has for the immediate future been stopped. It has been put to sleep, but it is not dead. The next approach may be from an international standpoint. It is worthy of note that neither of the political platforms contain a clause in favor of the nationalization of medicine. One of the candidates stated publicly that he would no more think of nationalizing the profession than he would his own profession, that of the law. The other candidate has now stated definitely that he would oppose the nationalization of medicine, so the committee suggests that we all consult our minds and our hearts and take our choice. We all know that political platforms often do not mean what they say, so it is well for us to be alert at all times.

The second threat, as seen by a certain percent of our profession, is that of the American hospitals. How much or how little actual practice of medicine the hospitals are doing is a mooted question. The hospital that is well organized and has high ethical standards is our greatest ally. They cannot exist without us and we can only do inferior work without them.

I doubt if any administrator of a "Class A" hospital means to infringe on the practice of medicine. It is easy to see that there are circumstances, emergencies, and so forth, which require those in charge of the hospital to act promptly in furnishing medical service, where there is no time to procure the particular doctor who is the choice of the patient or the family. In addition, there are certain services in a hospital: For instance the x-ray and pathology, which can best be done by one doctor who is employed on a proper basis by the hospital, and with the approval of the medical staff.

There are in Kentucky 149 hospitals, with a total of 16,610 beds. Louisville alone has 2,210 hospital beds. According to the population of Louisville and Jefferson County, there is a need in Louisville for 1,000 private hospital beds.

Including the mental and T.B. hospitals, there are in Kentucky 36 public hospitals; that is, supported by state, city, or county tax funds. This leaves a total of so-called private hospitals of 113. Of these, 41 come under the classifi-

cation of non-profit association, 26 belong to different church organizations, and 46 hospitals apparently are owned partly or entirely by doctors in the community. For the most part, all hospitals in the state are well managed and conducted for the best interest of the patient. The large majority require that those practicing in the hospitals be members in good standing of their County Medical Society. We believe that this requirement should be adhered to 100 per cent.

In the larger cities, nearly all of the hospitals have their own pathologist and radiologist. This, of course, is not possible in smaller hospitals. Both of these services are highly important and we commend the ingenuity, the thoughtfulness, and the judgment that is being shown in most smaller institutions in furnishing these services, although it requires considerable effort and some expense.

There are some two or three institutions in the state where there has been considerable criticism by the profession and resentment by the public as to the class of surgical and anesthesia service that is being rendered to the community. In these localities we would insist on a very thorough investigation and that a plan be sought to eradicate all unethical and inefficient conduct.

In the mining districts of our state; notably in Harlan, Pike, Perry and Bell, in the eastern part of the state, and in Hopkins and Muhlenberg, in the western part of the state, a new plan for hospitalization and the practice of medicine is being developed by the United Mine Workers of America. Sites have been selected and ground purchased for 5 of these hospitals in eastern Kentucky. A study of this is being made by our Advisory Committee on United Mine Workers Health and Welfare Fund. Dr. Carl H. Fortune is Chairman. They have had at least three meetings, gathering information and discussing the problem. Their report is now in the hands of the House of Delegates. This is a big problem and, to help clarify it, I quote from their summary:

"a) We believe the common purpose of the physicians of Kentucky and the UMWA Welfare Fund should be—

1) To make available the best medical and hospital care to the miners and their families.

2) To integrate the care furnished by the UMWA Welfare Fund with that provided by the local community.

3) To bring hospital facilities and medical care to isolated mine areas.

b) We believe that in the development of a medical program for the coal mining area certain general principles should be considered.

1) The development of new hospital and diagnostic facilities in the coal mining area

should be carefully coordinated with existing facilities in the community. This might well include discussion with responsible members of the medical profession before definite sites are selected for construction of such new facilities. We believe the physicians of Kentucky could be helpful in the planning state of a program which so vitally affects them.

2) A free choice of physicians and hospitals by the patient should be preserved in all communities where a choice can exist.

3) A fee-for-service of payment of physicians should be maintained except under unusual circumstances.

4) Control should be decentralized and the central organization should function only as a coordinating agency.

5) Physicians should remain free to practice in accordance with standards established by recognized medical agencies."

I would like to add to Dr. Fortune's summary that under no circumstances does a hospital or a corporation—this doesn't mean just the United Mine Workers, this means anywhere in the State—that no hospital or corporation make a profit from the services of any doctor that they furnish to the public.

At the present time there are licensed in Kentucky 2,394 M.D.'s. The average age of these practitioners is 51. There are 794 specialists and 1600 general practitioners.

While the number has increased somewhat in the last few years, there are still too few doctors in the country towns and in a few of the larger cities there are too many. Barring an upheaval, such as war or other catastrophe, the indications are bright for a much better distribution in the near future.

The last survey, in 1949, made in the United States with reference to the economic status of the physicians of the United States, showed an average income of the non-salaried physicians to be \$11,744.00, the all-salaried physician was \$8,434.00. For those in general practice, it was \$10,580.00; for the fully specialized \$16,608.00. Naturally, incomes varied in different areas of the United States. The highest average was on the Pacific Coast, Washington, Oregon and California. The lowest was in the New England States. Kentucky and Arkansas ranked toward the lowest in the whole list, but we do not have the figures for the individual states. These figures are taken from a statistical report made by Mr. Weinfeld and Mr. Dickinson, and they remind us that the survey was not entirely complete, but believe the figures will not vary much from what may be absolute. They state: "The rise in physicians' incomes for the last twenty years has been at about the same rate as the rise in the national income, per capita. More generally, the Ameri-

can people have been fair to their physician in an inflationary year from the standpoint of income; and vice versa."

Your committee does not have the exact percentage, but we feel sure in stating that only a small per cent of Kentucky doctors have really overcharged their patient for the service rendered. We are in an inflationary period where the cost of our rent, equipment, drugs, instruments, salaries and everything we use has advanced from 25 to 100%. Of course, our fees have been increased somewhat and we deplore the fact that there have been some excesses which give the advocates of nationalized medicine one of their best weapons.

The two complaints most commonly heard are: "The doctors overcharge and do not respond to calls." These statements are very damaging and are often repeated. This is not cheap talk but is the truth in many instances. This can and should be corrected in our own profession rather than by some government agency.

Ours is an honorable and noble profession. Properly practiced it is a physical rehabilitation, a mental uplift and a spiritual blessing. Let us keep it that way.

Respectfully submitted,

COMMITTEE ON MEDICAL PRACTICE

/s/ J. B. Lukins

J. B. Lukins, Louisville, Chairman
Gaithel L. Simpson, Greenville
Sam H. Flowers, Middlesboro
Carl H. Fortune, Lexington
Walter Lee Cawood, Harlan

Mr. Vincent Goodlett, Frankfort

SPEAKER HOUSTON: That report is being referred to Reference Committee No. 3. We are ready for the report of the Medical School Advisory Committee, Dr. Karl Winter.

REPORT OF MEDICAL SCHOOL ADVISORY COMMITTEE TO THE 1952 SESSION OF HOUSE OF DELEGATES

This Committee was formed in the fall of 1951 at the suggestion of J. Murray Kinsman, M. D., Dean of our Medical School. Our first assignment was to interview prospective applicants for this year's freshman class. Each member of the Committee checked on those in his community—the object being to help select the best suited for future physicians. I have had several interviews with Doctor Kinsman, to discuss the work of the Committee. We had one meeting of this Committee. It was very well attended and all the problems of operating a medical school were discussed. It is the hope and plan of this Committee to improve the relations between the School and the physicians in our State Medical Society. We feel that this has been neglected in the past,

and it is our intention to do everything which will help the progress of medical education in Kentucky. We desire to express our appreciation to Doctor Kinsman for his cooperation, and I wish to thank each member of this Committee for his whole-hearted support.

Respectfully submitted,

MEDICAL SCHOOL ADVISORY COMMITTEE

/s/ Karl Winter

Karl Winter, Louisville, Chairman
C. C. Howard, Glasgow
Charles A. Vance, Lexington
W. Vinson Pierce, Covington
Paul B. Hall, Paintsville
Clark Bailey, Harlan
George McClure, Greenville
G. L. Simpson, Danville
J. Vernon Pace, Paducah

SPEAKER HOUSTON: Dr. Winter is not here. The report is here. It is being referred to Reference Committee No. 3.

The Committee on Nurses Training, Dr. C. C. Howard.

DR. HOWARD: The report has been filed.

REPORT OF COMMITTEE ON NURSE TRAINING TO THE 1952 SESSION OF HOUSE OF DELEGATES

The following is the report of the Nursing Committee of the Kentucky State Medical Association: We had one joint meeting with the State Nursing Board, representatives of the Registered Nurses Association, the Practical Nurses Association, the State Board of Health, the Mental Health Division, the T. B. program, and other interested citizens. It was a very instructive, and we trust, a helpful meeting. The following points were agreed on to form a joint committee to consider and work out the following improvements in nursing facilities:

1. Additional schools for graduate nurses.
2. Establish schools for practical nurses.
3. Introduce the use of Medical Clerks in hospitals all over the state, thereby relieving the nurses of clerical duties.
4. Establish training schools for orderlies, giving certificates after prescribed course is taken.
5. Establish schools for both graduate and practical nurses for colored people.
6. Set up practical training program in Mental and T. B. Hospitals.

The joint committee has been appointed and will meet within the near future with the new State Nursing Board.

Respectfully submitted,

COMMITTEE ON NURSE TRAINING

/s/ C. C. Howard

C. C. Howard, Glasgow, Chairman

W. Vinson Pierce, Covington
 Charles B. Stacy, Pineville
 W. O. Johnson, Louisville
 Philip J. Begley, Harlan

SPEAKER HOUSTON: The report is being referred to Reference Committee No. 3.

The report of the Professional Relations Committee, Dr. E. W. Jackson, Paducah.

**REPORT OF PROFESSIONAL RELATIONS
 COMMITTEE TO THE
 1952 SESSION OF HOUSE OF DELEGATES**

The Professional Relations Committee begs to submit the following report for the previous year:

At the time of the writing of this report there has been only one formal meeting of the Committee during the past year, but all complaints from patients up to this time have been investigated and attempt made to settle them, and all have been considered by the Committee as a whole. It is intended to have another meeting before the end of the year, in order that the entire Committee shall consider such other complaints as may be made up to that time.

There has been a total of sixteen complaints submitted by patients, or their agents, against physicians of the State during the past year. These complaints have been for various causes, the majority of them on account of the fee charged. There have been a few complaints on account of being unable to secure physicians and a few about the type of service received.

The patients making the complaints and, also, the doctors have received letters from the Committee, requesting them to make an effort to reach a satisfactory agreement. In the main, the doctors have been very cooperative and in some instances have gone further than would seem necessary, in order to have the patient satisfied. It can also be said that in the majority of instances the patients appeared to be entirely sincere about their complaints and in a few cases, it must be admitted, that it appeared they had cause for dissatisfaction.

In a few instances the physicians have completely removed the charge from their books and the patients were so notified. However, in the majority of cases the patient making the complaint never answered the letter from the Committee one way or another, even where the charge had been marked off the books and in two cases, neither the patient or physician answered our correspondence.

For the most part, the Committee is of the opinion that in the majority of cases investigated, the main trouble was due to a lack of understanding of what service was rendered and what the fee was intended to cover, and begs to suggest that where there is any likeli-

hood of misunderstanding, an itemized statement be furnished the patient. Certainly, it should be furnished when requested.

This one thing should clarify many of the misunderstandings between the patient and physician.

Respectfully submitted,
**PROFESSIONAL RELATIONS
 COMMITTEE**
 /s/ E. W. Jackson
 E. W. Jackson, Paducah, Chairman
 Guy Aud, Louisville
 Charles A. Vance, Lexington
 Hugh L. Houston, Murray
 Sam A. Overstreet, Louisville

SPEAKER HOUSTON: Dr. Jackson is not here. It is being referred to Reference Committee No. 3.

The report of the Committee on Training of Ambulance Attendants, Dr. C. C. Howard.

DR. HOWARD: The report is filed.

**REPORT OF COMMITTEE ON TRAINING OF
 AMBULANCE ATTENDANTS TO THE
 1952 SESSION OF HOUSE OF DELEGATES**

This is a report of a joint committee of the Southeastern Surgical Congress and the Kentucky State Medical Society. Each organization is vitally interested in instructing the ambulance attendants in caring for the sick and injured, they are called upon to transport to a hospital, patient's home, or doctor's office. Kentucky has about five hundred ambulances, operated by highly intelligent men. They are ready and will gladly accept any training we will give them. At a meeting with their representatives, it was agreed that a small comprehensive manual, written by this committee, should be the first step. Then the medical societies, county or district, should set up training committees to teach, as they see fit, the ambulance attendants at stated times each year. The Ambulance Committee recommends that each county or district set up a committee to train ambulance attendants.

We are filing with the Reference Committee a proposed manual. Please visit the Committee and read it. We are open for constructive suggestions so as to make this manual usable to the front line men.

Respectfully submitted,
**COMMITTEE ON TRAINING OF
 AMBULANCE ATTENDANTS**
 /s/ C. C. Howard
 C. C. Howard, Glasgow, Chairman
 Paul B. Hall, Paintsville
 J. Duffy Hancock, Louisville
 Hugh L. Houston, Murray
 Carl Norfleet, Somerset
 Gaithel Simpson, Greenville

Lillian H. South, Louisville
 Clyde C. Sparks, Ashland
 Charles B. Stacy, Pineville
 Robert R. Starr, Glasgow

SPEAKER HOUSTON: The report is referred to Reference Committee No. 3.

Report from the Committee for the World Medical Association, Dr. Clark Bailey.

DR. BAILEY: Mr. Chairman, the report has been filed.

REPORT OF COMMITTEE ON WORLD MEDICAL ASSOCIATION TO THE 1952 SESSION OF HOUSE OF DELEGATES

Too few of our Kentucky doctors have membership in the World Medical Association. In addition to the purpose of scientific improvement through membership in the international organization, there is the opportunity to demonstrate the superiority of the practice of medicine under the system of free enterprise to the other nations of the world.

The World Health Organization, a subcommittee of the United Nations, advocates many practices which we, as free Americans, cannot accept—purely socialistic in nature.

The International Labor Organization, a subcommittee of the United Nations, has been most active in this country and throughout the world in an effort to socialize medicine. The organization has contributed much money for this purpose. Its secretary, Earnest Rhymer, testified before a U. S. Senate Committee that he was a card-carrying Communist.

We can combat the possibility of regimentation of our profession via treaty by giving our support, through membership, to the World Medical Association—an organization working with doctors in all countries of the world to preserve the practice of medicine as an unshackled profession.

Respectfully submitted,
COMMITTEE ON WORLD MEDICAL ASSOCIATION

/s/ Clark Bailey

Clark Bailey, Harlan, Chairman
 C. M. Edelen, Louisville

John P. Glenn, Russellville

J. Gant Gaither, Hopkinsville

George Asher, Pineville

Robert W. Bushart, Fulton

William R. Miner, Covington

SPEAKER HOUSTON: Report is here. It is being referred to Reference Committee No. 3.

We are now ready for the report of the Advisory Committee on Blood Banks, Dr. Beard of Louisville.

DR. BEARD: The Committee had its first meeting this afternoon, and I would like to present a supplementary report as we indicated in our report.

REPORT OF ADVISORY COMMITTEE ON BLOOD BANKS TO THE 1952 SESSION OF HOUSE OF DELEGATES

The Advisory Committee on Blood Banks was appointed in July, 1952 by the President, Clark Bailey, M. D. The purpose of the Committee is to consider all phases of blood banks and make recommendations as to more efficient collection and distribution of blood, as well as help in any problems that may arise.

The Committee has not had an opportunity to have a meeting, because of its recent appointment and interfering vacation schedules. However, a meeting will be held during the Annual Meeting of the Kentucky State Medical Association.

Respectfully submitted,

**ADVISORY COMMITTEE ON
 BLOOD BANKS**

/s/ Marion F. Beard

Marion F. Beard, Louisville,
 Chairman

Burr Atkinson, Campbellsville

W. P. Blackburn, Frankfort

George McClure, Danville

Hubert C. Jones, Berea

Dana Snyder, Hazard

A. J. Miller, Louisville

H. C. Burkhart, Harlan

Samuel Adams, London

Paul York, Glasgow

John B. Floyd, Jr., Lexington

Luther Bach, Lexington

David Y. Keith, Paducah

W. Mountjoy Savage, Maysville

SPEAKER HOUSTON: The Chair has ruled that any time the Committee can give any report it cares to in connection with its committee report. If you wish to speak on that point, you can.

DR. BEARD: The Committee on Blood Banks was formed by Dr. Bailey in the past summer because of the increasing complexities of the community blood bank situation in Kentucky. We had our first meeting this afternoon.

SUPPLEMENTAL REPORT ADVISORY COMMITTEE ON BLOOD BANKS

The modern complexities of Blood Grouping and the increased use of blood makes the operation of a single hospital blood bank difficult. The community-wide blood bank has, since its inception on a wide spread scale after World War II, demonstrated that it can meet the needs of a modern transfusion service. Furthermore, these needs can be met without a charge for the blood itself and with the community meeting the cost of collecting, processing and distributing the blood in one way or another. A community bank can also, in ad-

dition to its transfusion service, exercise certain advantages such as Immune Globulin, serum albumin, plasma and anti-hemophilic plasma. A community bank also is a nucleus, which can be rapidly expanded in time of national emergency to furnish blood and blood derivatives to the Armed Forces and to Civilian Defense.

The Advisory Committee on Blood Banks therefore recommend that the Kentucky State Medical Association endorse Community Blood Banks.

We further recommend that:

(1) These Blood Banks be supervised by licensed MD members of this association but financed and staffed by community organizations capable of furnishing community funds and volunteers such as the American Red Cross or similar organizations.

(2) That the members of this association actively take part in these community banks by serving on their Advisory Committee and by actively informing the community of the advantages of community-wide pre-depositing of blood in these banks.

(3) That all community blood banks in Kentucky be operated under regulations of the Biological Division National Institutes of Health as all other biological manufacturers are, so that free exchange of blood between the various banks can be made and the most efficient use of blood be attained.

(4) That the principle of group pre-deposit of blood rather than individual replacement is the most desirable means of recruitment of blood donors but that members of this association assist in the recruitment either by Group Pre-deposit or by Individual replacement when their patients are recipients of blood.

(6) It is apparent that the use of blood has in some instances increased to the point of diminishing returns. In view of the fact that blood transfusion is not entirely free of danger, your Committee recommends that each case be carefully evaluated before a transfusion is given. This should in no way limit the amount of blood used when needed and at the same time insure that no risk is taken unless indications for blood are definite. We suggest that blood should not be used just because it is readily available.

(7) All cooperating hospitals assist in the orderly distribution of blood which will assist in the best promotion of recruitment of blood.

Respectfully submitted,

ADVISORY COMMITTEE ON
BLOOD BANKS

/s/ Marion F. Beard

Marion F. Beard, Louisville,
Chairman

Burr Atkinson, Campbellsville

W. P. Blackburn, Frankfort
George McClure, Danville
Hubert C. Jones, Berea
Dana Snyder, Hazard
A. J. Miller, Louisville
H. C. Burkhart, Harlan
Samuel Adams, London
Paul York, Glasgow
John B. Floyd, Jr., Lexington
Luther Bach, Lexington
David Y. Keith, Paducah
W. Mountjoy Savage, Maysville

SPEAKER HOUSTON: His report and supplementary report will be referred to Committee No. 4.

We are ready for the report of the Advisory Committee on Cancer, Dr. Aud.

DR. AUD: The report is filed.

REPORT OF ADVISORY COMMITTEE ON CANCER TO THE 1952 SESSION OF HOUSE OF DELEGATES

The problem of cancer and its control, in spite of the many recent advances, is a vast one. Its solution lies in attacking on the broadest possible front: education of the public, supporting facilities for detection, and providing diagnosis and treatment within the reach of all.

One of the objectives of the Committee on Cancer has been to gain recognition on the part of physicians and laymen of the importance of cancer as a public health problem. Every effort has been made to acquaint the medical profession with the latest developments in diagnosis and treatment of cancer; and to encourage establishment of specialized cancer clinics, staffed by trained medical and surgical specialists. The medical profession must increase its current knowledge of cancer and keep well informed of the many new advancements that are constantly being made in the fields of diagnosis and treatment, if it is to solve the cancer problem.

The Committee on Cancer wishes to commend the members of the Kentucky State Medical Association who have volunteered their services on the staffs of the sixteen Cancer Clinics and the Cancer Mobile. Without their unselfish devotion and attendance at these clinics, many medically indigent cancer cases would not have had adequate treatment.

We wish to pay tribute, also, to the Kentucky Division, the American Cancer Society, the Kentucky State Department of Health, and the United States Public Health Service for their interest and leadership in the field of cancer control. These agencies have rendered invaluable assistance to the Commonwealth in providing clinical facilities, equipment, professional educational materials, and general services to the Kentucky State Medical Association.

Appropriations

During the fiscal year: July 1, 1951, through June 30, 1952, the General Assembly of the Commonwealth of Kentucky appropriated the sum of thirty-five thousand dollars (\$35,000.00) for use in cancer control programs. The United States Public Health Service allocated the sum of seventy-five thousand, seven hundred and twelve dollars (\$75,712.00) to the Cancer Control Section of the State Department of Health. Volunteer contributions to the Kentucky Division, American Cancer Society, amounted to two hundred and three thousand, seven hundred seventy-seven dollars (\$203,777.00). These appropriations were expended under the direction of the Committee on Cancer Control, Kentucky State Medical Association, the State Health Commissioner and the Board of Directors, Kentucky Division, American Cancer Society. Programs were coordinated and planned in order to prevent duplication and, also, to expend the funds judiciously.

Education

Through the joint cooperation of the American Cancer Society and the National Cancer Institute, two outstanding scientific cancer films, in technicolor with sound, were made available to the medical profession in Kentucky. These films: "Cancer of the Gastrointestinal Tract" and "Uterine Cancer" have had wide circulation.

Through the educational program of the Kentucky Division, American Cancer Society, every member of the medical profession in the Commonwealth has received the bi-monthly journal, **CA, A Bulletin of Cancer Progress**. Each physician also received scientific monographs entitled: **Cancer of the Esophagus and Stomach, Cancer of the Lung, and Malignant Lymphomas and Leukemias**. The Speakers Bureau for the medical profession continues to function with fifty-two members of the K.S.M.A. serving on the Bureau.

Clinic Referrals

A member of the Kentucky State Medical Association may refer any medically indigent cancer patient to a Cancer Clinic for diagnosis and/or treatment when it is suspected that there is evidence of malignancy. These Cancer Clinics are supported by the respective hospitals, State Department of Health, and the Kentucky Division, American Cancer Society. The only requirement for admission to the

Cancer Clinic is a statement by the referring physician that the patient is medically indigent and has symptoms suggestive of cancer. A short clinical history must be sent with the patient.

CANCER CLINICS

Barren County

T. J. Samson Community Hospital
Glasgow, Kentucky

Bell County

Middlesboro Hospital
Middlesboro, Kentucky

Boyd County

King's Daughters Hospital
Ashland, Kentucky

Christian County

Ida Chappell Cancer Clinic
Jennie Stuart Memorial Hospital
Hopkinsville, Kentucky

Fayette County

Good Samaritan Hospital
Lexington, Kentucky
St. Joseph Hospital
Lexington, Kentucky

Henderson County

Methodist Hospital
Henderson, Kentucky

Jefferson County

Central State Hospital
Lakeland, Kentucky
Red Cross Hospital
Louisville, Kentucky
St. Joseph Infirmary
Louisville, Kentucky
General Hospital
Louisville, Kentucky

Kenton County

William Booth Memorial Hospital
Covington, Kentucky

McCracken County

Riverside Hospital
Paducah, Kentucky

Muhlenberg County

Muhlenberg Community Hospital
Greenville, Kentucky

Pike County

Methodist Hospital
Pikeville, Kentucky

Warren County

City Hospital
Bowling Green

MEDICALLY INDIGENT CANCER CASES SEEN IN CANCER CLINICS

From July 1, 1951, Through June 30, 1952

CANCER CLINIC	Clinic Sessions	Volunteer Physicians	Number of Patients
T. J. Sampson Hospital.....	43	197	231
Middlesboro Hospital	21	76	180
King's Daughters Hospital.....	43	183	429
Ida Chappell Cancer Clinic.....	40	163	245
Good Samaritan Cancer Clinic.....	42	455	1,493
St. Joseph Hospital	42	330	497
Methodist Hospital—Henderson	42	119	164
Central State Cancer Clinic	13	54	214
General Hospital Cancer Clinic.....	42	819	846
Mobile Unit	17	36	835
St. Joseph Infirmary Cancer Clinic.....	41	1,148	1,053
Red Cross Hospital Cancer Clinic	18	98	74
Wm. Booth Memorial Hospital Cancer Clinic..	22	198	566
Riverside Hospital Cancer Clinic	19	55	104
Muhlenberg Hospital Cancer Clinic.....	24	118	95
Methodist Hospital—Pikeville	42	222	227
City Hospital—Bowling Green	36	289	209

Tissue Biopsy Program

With the assistance and cooperation of the Kentucky Society of Pathologists, the Tissue Biopsy Program continues to function in a most satisfactory manner. This service makes it possible for any member of the medical profession to have tissue specimens studied without charge to the medically indigent patient or referring physician. The service is administered by the Cancer Control Section of the State Department of Health. During the past fiscal year, one thousand and forty-eight specimens were submitted for study.

Cancer Registry

The Cancer Registry is fulfilling a great need in our study of cancer in Kentucky. Physicians and hospitals are faithfully reporting all their cases and the stage is being reached whereby good statistical studies will be possible. Since the inception of the Registry in December, 1949, 24,484 case records have been recorded and tabulated. In the last fiscal year, 4,743 cases were registered.

Respectfully submitted,
ADVISORY COMMITTEE ON
CANCER

/s/ Guy Aud

Guy Aud, Louisville, Chairman
J. Farra Van Meter, Lexington
Jesshill Love, Louisville
W. H. Pennington, Lexington
John W. Meredith, Scottsville
Richard J. Rust, Newport

SPEAKER HOUSTON: The report is being referred to Reference Committee No. 4.

The report of the Advisory Committee on Crippled Children, Dr. Fischer of Louisville.

**REPORT OF ADVISORY COMMITTEE ON
CRIPPLED CHILDREN TO THE
1952 SESSION OF HOUSE OF DELEGATES**

Attached is a copy of the annual report of the Kentucky Crippled Children Commission to the Advisory Committee on Crippled Children of the Kentucky State Medical Association. The Advisory Committee on Crippled Children has not deemed it necessary to meet during the year of 1951-52, because several members of the Committee are in close contact with the activities of the Crippled Children Commission, and are actively engaged in supervising the activities of the Crippled Children Commission.

In going over the report of the Crippled Children Commission, it is interesting to note that the per capita cost for the treatment of the individual case to the crippled children during the year 1951-52 was reduced considerably as compared with the 1950-1951 cost. The total number of patients treated during 1951-1952 was greater than in 1950-1951.

Greater provision is being made each year for the interests of crippled children in Kentucky. During the last year, the Kentucky Society for Crippled Children opened a convalescent hospital in Lexington and just recently the Kosair Hospital in Louisville opened a large new clinic for crippled children. This new clinic will serve all the surrounding area and

will allow the examination of crippled children at the hospital rather than at the doctors' offices. This will allow the crippled child to receive any physical therapy treatment that is needed on the day of his visit to his doctor as well as any brace change that may be necessary. This is an excellent and added service to the crippled child.

It is the opinion of the members of the committee that the Kentucky Crippled Children's

Commission functions at a high state of efficiency.

Respectfully submitted,
ADVISORY COMMITTEE ON
CRIPPLED CHILDREN
/s/ K. Armand Fischer
K. Admand Fischer, Louisville,
Chairman
Charles C. Carr, Lexington
Charles F. Wood, Louisville
Otto H. Salsbury, Covington

REPORT TO THE MEDICAL SOCIETY OF ACTIVITIES OF THE KENTUCKY CRIPPLED CHILDREN COMMISSION

July 1, 1951 through June 30, 1952

Given below are statistics for the fiscal year July 1, 1951, through June 30, 1952, showing services given by the Kentucky Crippled Children Commission, the official State agency for the care of white and colored crippled children under twenty-one years of age. The per capita cost in the fiscal year 1951-1952 was \$252.77, as compared to \$316.76 in 1950-51. The total number of patients treated was 3,104 in 1951-52, as compared to 3,082 in 1950-51, an increase of 22.

1,899 treated 1948-49 at per capita cost \$351.99 3,082 treated 1950-51 at per capita cost \$316.76
2,481 treated 1949-50 at per capita cost \$352.54 3,104 treated 1951-52 at per capita cost \$252.77

	Fiscal Year 1950-51	Fiscal Year 1951-52	Increase or Decreases
Number of examinations at itinerant field clinics.....	1,990	1,914	— 76
Number of examinations at regular monthly or bi-monthly clinics:			
Ashland	569	579	+ 10
Covington	672	669	— 3
Lexington: General Clinics	1,279	1,247	— 32
Cerebral Palsy Clinics	325	341	+ 16
Louisville: General Clinics	2,299	1,819	— 480
Cerebral Palsy Clinics	427	447	+ 20
Total examinations at free diagnostic and follow-up clinics.....	7,561	7,016	— 545
Total examinations in doctors' offices—orthopedists	2,238	2,661	+ 423
Total examinations in office of special consultants	313	326	+ 13
Total hospital admissions	1,757	1,166	— 591
Total hospital days	62,794	43,361	— 19,433
Total convalescent hospital admissions	348	297	— 51
Total convalescent hospital days	13,654	11,481	— 2,173
Total out-patient cast applications and follow-up	1,195	801	— 394
Total out-patient physical therapy treatments (Exclusive of cerebral palsy cases)	9,085	5,456	— 3,629
Total home visits by county public health nurses and orthopedic public health nurses commission staff.....	1,354	2,513	+ 1,159
Referrals to Vocational Rehabilitation	469	507	+ 38
Cerebral Palsy Program			
Individual patients served through Program.....	427	505	+ 78
Total examination at:			
Lexington Clinics	325	341	+ 16
Louisville Clinics	427	447	+ 20
Total physical therapy treatments	2,841	2,303	— 538
Total occupational therapy treatments	1,870	1,388	— 482
Total speech therapy treatments	1,089	1,439	+ 350
Total psychological examinations	211	292	+ 81

It will be noted that the per capita cost in the fiscal year 1951-52 is \$252.77, a total of \$63.99 less than the per capita cost in 1950-51 of \$316.76. This decrease can be explained by the facts that: a) The total hospital days decreased from 62,794 to 43,361—a drop of 19,433 days; the total convalescent hospital days decreased from 13,654 to 11,481—a drop of 2,173 days. There were 591 fewer hospital admissions, and the cost of hospitalization is a factor in causing the per capita cost to rise or fall. b) The Commission did not accept adult polios or acute polios in the fiscal year 1951-52; and, therefore, did not incur the expenses shown in the previous budget for special nurses, doctors' fees, and other costs for such patients. c) The Commission treated 3,104 patients, 22 more than last year; but with the reduction of hospital admissions, more patients were examined and treated on an out-patient basis. Out-patient care cost is always lower for orthopedic patients than in-patient care.

The total examined at free diagnostic and follow-up clinics decreased from 7,561 to 7,016, or a decrease of 545 examinations. This drop was due to the cancellation of sixteen orthopedic clinics in May and June 1952—four in Lexington and four in Louisville for each of the two months.

Physical therapy and occupational therapy treatments decreased due to resignation of therapists and inability to secure replacements, as well as a reduction in the number of patients referred for therapy treatments.

Hospital centers are in Ashland, Covington, Lexington, and Louisville. Physical therapy centers are open full time at Lexington and Louisville and one week each month at Ashland, Covington, Owensboro, and Paducah. The seven-member Commission Board and the doctors serving on the medical staff determine administrative and medical policies. The staff consists of:

- 1 Medical Director (part-time)
- 1 Director (full-time)
- 3 Medical-Social Consultants
- 3 Orthopedic Public Health Nurses
- 4 Physical Therapists
- 1 Speech Therapist
- 1 Psychologist
- 1 Administrative Assistant
- 16 Secretarial and Clerical Workers

The Kentucky Crippled Children Commission expresses its sincere appreciation for the fine help, interest, and cooperation of the State and County Health Departments, of the doctors serving on the Commission Staff, and of the medical profession as a whole in making the service for crippled children possible.

SPEAKER HOUSTON: The report is filed and being referred to Reference Committee No. 4.

The Advisory Committee on General Practice, Dr. J. A. Bishop, Jeffersontown.

REPORT OF ADVISORY COMMITTEE ON GENERAL PRACTICE TO THE 1952 SESSION OF HOUSE OF DELEGATES

As Chairman of the Advisory Committee on General Practice for the State Medical Association, I wish to file the following report:

There has been no meeting of this Committee during the year, due to the fact that nothing has been referred to this Committee for action.

A supplementary report will be filed at a later date, should there be anything referred to us for consideration.

Respectfully submitted,

/s/ J. A. Bishop

J. A. Bishop, Jeffersontown,
Chairman

Travis Pugh, Bowling Green
John W. Somerville, Maysville
William M. Brown, Corbin

SPEAKER HOUSTON: Dr. Bishop is not here. The report is in and being referred to Reference Committee No. 4.

We are ready for the report of the Advisory Committee on Industrial Medicine and Surgery, Dr. Rowntree.

DR. ROWNTREE: The report has been filed.

REPORT OF THE ADVISORY COMMITTEE ON INDUSTRIAL MEDICINE AND SURGERY TO THE 1952 SESSION OF HOUSE OF DELEGATES

Industrial Medicine in Kentucky is on the move. During the past year the number of industrial workers has been increased by about fifty thousand in our State. Last year there were 104 full-time registered industrial nurses in 63 plants in Kentucky. This year there are 151 full-time registered nurses in 83 plants.

The Kentucky State Association of Registered Nurses has adopted recommended employment standards for industrial nurses. To indicate the interest of the total State nursing group in industrial nursing, the State Association this year will have as its guest speaker Dr. William H. Rice, Chief Surgeon from Armco Steel. For the first time a public health nurse trained in industrial nursing will be added to the staff of the Louisville and Jefferson County Department of Public Health as an industrial nurse consultant.

In the past year the Second Louisville Area Industrial Health Conference, sponsored by the Chambers of Commerce in this area and various other interested agencies, had a dinner meet-

ing at the Pendennis Club. One hundred persons were present. Four speakers represented industrial medicine, nursing, industrial hygiene and management.

The Kentucky industrial physicians had one meeting during the year to discuss ways and means of promoting more interest in the whole field of industrial medicine in this State and bringing more physicians engaged in industrial practice together.

Respectfully submitted,

ADVISORY COMMITTEE ON INDUSTRIAL MEDICINE AND SURGERY

/s/ Gradie Rowntree

Gradie R. Rowntree, Louisville,
Chairman

R. W. Robertson, Paducah

Clyde C. Sparks, Ashland

Richard J. Rust, Newport

Ira N. Kerns, Louisville

Walter L. Cawood, Harlan

SPEAKER HOUSTON: The report has been filed and being referred to Reference Committee No. 4 for study.

The report of the Advisory Committee on Mental Hygiene and Mental Institutions, Dr. Ackerly of Louisville.

DR. ACKERLY: The report has been filed.

REPORT OF ADVISORY COMMITTEE ON MENTAL HYGIENE AND MENTAL INSTITUTIONS TO THE 1952 SESSION OF HOUSE OF DELEGATES

Several advances of historical importance have been made on behalf of the mental patients in Kentucky since last year:

1. The appointment of Frank Gaines, M. D., as Director of Hospitals and Mental Hygiene by Governor Wetherby on May 1, 1951. Doctor Gaines is a Kentuckian and a qualified specialist in psychiatry.

2. The creation of a new department of the State Government; namely, that of the Department of Mental Health, with Doctor Gaines as its first Commissioner, acting directly under the Governor. All four State Hospitals for mental patients are now functioning in this Department, newly created by the 1952 Legislature. The only institution not in the Department is the Training School at Frankfort. That is still functioning under the Department of Welfare under Commissioner Luther Goheen.

3. The establishment of a training program through the Department for all personnel.

4. Increase in salaries for State Hospital doctors.

5. It is now possible for State Hospital personnel to be sent to recognized centers for specialized training, with full salary paid by the

State. Several State Hospital nurses have been given postgraduate training at the Norton Psychiatric Clinic, Norton Memorial Infirmary, under this arrangement.

6. The appointment of a full-time assistant Commissioner, Richard Jarvis, M. D., formerly Clinical Director of Psychiatry at the Norton Psychiatric Clinic, Norton Memorial Infirmary, Louisville.

7. Four cottages have been built for doctors at Lexington and three at Hopkinsville.

8. The headquarters of the Department of Mental Health was moved from Frankfort to the State Board of Health Building in Louisville, so that all health, including mental health, could be concentrated and correlated both from the point of view of administration as well as training.

9. Central State Hospital, Lakeland, has received approval from the American Medical Association for one year residency training in psychiatry. The University of Louisville School of Medicine has developed a rotating plan of training for first year residents in psychiatry—four months at Central State Hospital, four months at the Louisville Veterans Administration Hospital, and four months at the Louisville General Hospital. In this year residents can apply for continuation of their training at the Norton Psychiatric Clinic and Louisville Mental Hygiene Clinic and Child Study School, both affiliated with the Department of Psychiatry and the Department of Neurology of the Medical School.

10. There has been some agitation to concentrate elderly people in one hospital, which this Committee deplores and is violently opposed to. Seniles and elderly psychotic patients we feel should be treated at each of the four State Hospitals where medical staffs are available for the treatment of all mental illness, including geriatrics, tubercular, and mental patients with a variety of physical infirmities.

11. It is hoped that with better living conditions and higher salaries more doctors will be attracted into the State service.

Recommendations:

1. The infirmary and T. B. building at Lexington are in bad condition and new buildings are needed at once.

2. A survey of the Criminal Insane Section at Lakeland needs to be conducted.

Respectfully submitted,

ADVISORY COMMITTEE ON MENTAL HYGIENE AND MENTAL INSTITUTIONS

/s/ S. Spafford Ackerly

S. Spafford Ackerly, Louisville,
Chairman

Frank M. Gaines, Louisville
 George H. Wilson, Lexington
 Billy K. Keller, Louisville
 John P. Bell, Louisville

SPEAKER HOUSTON: Report has been filed and referred to Reference Committee No. 4.

The Advisory Committee on Obstetrics, Dr. McDevitt.

DR. McDEVITT: The report has been submitted.

REPORT OF ADVISORY COMMITTEE ON OBSTETRICS TO THE 1952 SESSION OF HOUSE OF DELEGATES

The Committee on Obstetrics had comparatively little work to do during the past year.

We have heard nothing from the Committee on Maternal and Child Care of the American Medical Association, pertaining to the questionnaire attempting to evaluate results of the E.M.I.C. program (Emergency Maternal and Infant Care Program) that was used during World War II.

This Committee feels that a thorough study of maternal deaths in Kentucky should be made. We realize that Dr. Cathryn Handelman has done some work on the statistics of this subject. What this Committee would like to do is screen every doctor in the state who does obstetrics. It would be emphasized that this is only a study and in no way would be made embarrassing to any physician. All cases would be handled by code numbers. After collecting enough cases, the Committee would meet every few months to discuss the cases and see where we are deficient in this state.

This would necessitate the appropriation of two or three hundred dollars a year for printing, stamps, etc., by the Kentucky State Medical Association for this Committee. Dr. Ed Masters of Louisville, Kentucky, has done some preliminary ground work for this study and has gotten a promise from the State Board of Health to give us their full cooperation on this project.

Respectfully submitted,

**ADVISORY COMMITTEE ON
 OBSTETRICS**

/s/ C. J. McDevitt

C. J. McDevitt, Murray, Chairman
 Rudy F. Vogt, Louisville
 Stanley S. Parks, Lexington
 Charles D. Cawood, Middlesboro
 Joseph T. Moloney, Covington

SPEAKER HOUSTON: The report has been submitted and being referred to Reference Committee No. 4.

The report of the Pediatric Advisory Committee, Dr. W. W. Nicholson, Louisville.

REPORT OF THE PEDIATRIC ADVISORY COMMITTEE TO THE 1952 SESSION OF HOUSE OF DELEGATES

The Pediatric Advisory Committee held a joint meeting with the Obstetric Advisory Committee and the Division of Maternal and Child Health in the fall of 1951, during the Kentucky State Medical Association meeting.

Several items were discussed and suggestions given.

One point which both committees felt needed revision was the State law requiring AgNO_3 in babies eyes. They suggested that the law read—"AgNO₃ or any other medically proven acceptable substitute"—However, the State Board of Health felt that the law should remain as it is until a substitute, which can completely replace AgNO_3 in rural as well as urban practice, becomes available.

Infant mortality in Kentucky was discussed. It is still high in comparison with the national average and in comparison with most states. Twenty Gordon-Armstrong incubators have been placed in rural areas for use by general practitioners, chiefly for heat and humidity for the baby in the home. A series of one-day institutes were held for the public health nurses as refreshers in prematurity and premature care, in order to make them feel more capable of advising mothers, in conjunction with the doctor, in proper care of the infant.

The possibility of an infant mortality study was suggested. This has been started on a "spot check" basis and it is hoped some constructive suggestions will devolve from this study.

Importance, value to physicians, and usability of vital statistics materials was brought up by the Committee. The committees agreed almost unanimously that vital statistics were valuable to them as practicing physicians.

Members of the Committee deplored the fact that suggestions to discontinue immunizations during the summer months were widespread. They felt, individually and collectively, that, since most immunizations were or should be done in early infancy, these should be continued as the trauma of the preventable diseases might be far greater than poliomyelitis itself. Also, the good gained by the years of training the public to immunizations would be lost if we started postponing the procedure for a period of time for various reasons that may not be truly valid. All pediatricians present had continued their immunizations through the summer months—especially on the infants.

It was suggested that prenatal Kahns should be taken both in early pregnancy and at the beginning of the last trimester. This is a standard procedure at the Louisville General Hospital. This was proposed to the State

Board of Health, as an addition to the pre-natal law.

The toll of accidents among pre-school and school children was discussed. It was recommended that the State Department of Health participate in an accident prevention program. Preliminary plans had been laid by the State Department of Health. The Division of Maternal and Child Health was preparing a pamphlet on pre-school home accidents.

Various pamphlets designed by the Division of Maternal and Child Health were reviewed and discussed.

A report on the progress of the hearing conservation program was given.

Respectfully submitted,
ADVISORY COMMITTEE ON
PEDIATRICS

/s/ W. W. Nicholson

W. W. Nicholson, Louisville,
Chairman

Murvel C. Blair, Frankfort

Robert L. Biltz, Newport

Lon C. Hall, Paintsville

Daniel B. McIlvoy, Jr., Bowling
Green

SPEAKER HOUSTON: Dr. Nicholson is not here. His report is, and is being referred to Reference Committee No. 4.

The report of the Advisory Committee on Physical Therapy, Dr. McDaniel Ewing of Louisville.

REPORT OF ADVISORY COMMITTEE ON PHYSICAL THERAPY TO THE 1952 SESSION OF HOUSE OF DELEGATES

No pressing business has come before the Physical Therapy Committee and no formal meetings have been held during the past year.

Respectfully submitted,
ADVISORY COMMITTEE ON
PHYSICAL THERAPY

/s/ W. M. Ewing

W. McDaniel Ewing, Louisville,
Chairman

Edward B. Mersch, Covington

M. D. Garred, Ashland

Owen B. Murphy, Jr., Lexington

Robert W. Hahs, Murray

William K. Massie, Jr., Lexington

SPEAKER HOUSTON: Dr. Ewing is not here. His report is here and being referred to Reference Committee No. 4.

The report of the Advisory Committee on Rural Health, Dr. O'Nan.

DR. O'NAN: The report is on file.

REPORT OF ADVISORY COMMITTEE ON RURAL HEALTH TO THE 1952 SESSION OF HOUSE OF DELEGATES

Following up the recommendations of last year, the President, Clark Bailey, M. D., appointed our committee as listed below to serve and represent the fifteen councilor districts. They have attended meetings with considerable sacrifice and all but three have continued to serve. These, for various good reasons, have asked to be relieved.

During February and March of 1952 your Chairman attended the Seventh National Rural Health Conference in Denver, Colorado, and brought numerous ideas for the progress of our programs.

By far, the greatest progress has been the First Rural Health Conference held in Louisville, May 7, and 8. It was attended by more than two hundred. Members of the Kentucky State Medical Association numbered fifty-one and a goodly number of the various co-sponsors listed here:

Division of Vocational Education, Department of Education.

Division of Child Welfare, Department of Economic Security.

Extension Service, University of Kentucky.

Kentucky Congress of Parents and Teachers.

Kentucky Farm Bureau Federation

Kentucky Hospital Association.

Kentucky Pharmaceutical Association.

Kentucky State Association of Registered Nurses.

Kentucky State Dental Association.

Kentucky State Department of Health.

University of Louisville School of Medicine.

Woman's Auxiliary to the Kentucky State Medical Association.

The theme of this Conference "We Have Waited Long Enough" certainly was carried out, by the way in which the various members have started working.

Reports of the Committee for the Constitution and By-Laws and others have been received, but as yet, no official Constitution has been adopted.

It is the wish of the Committee to continue its work, that local Health Councils be formed, and begin to work on problems. One suggestion would be the assistance of furthering the Tuberculosis Society, which is Kentucky's number one health problem.

Another worthwhile association has been made in the Kentucky State Agriculture Council, of which the Rural Health Council is a member. This new organization was brought into being at the suggestion of Governor Lawrence Wetherby, with the objective of improving the agriculture of Kentucky. Meetings have

been held in Louisville and at Hardinsburg, Kentucky.

Respectfully submitted,
ADVISORY COMMITTEE ON
RURAL HEALTH

/s/ Walter L. O'Nan

Walter L. O'Nan, Henderson,

Chairman

D. Y. Keith, Paducah

Thomas H. Milton, Owensboro

Donald W. Anderson, Madisonville

Ruel T. Routt, Sonora

J. Audin Bishop, Jeffersontown

D. G. Miller, Jr., Morgantown

Harry K. Dillard, Warsaw

George H. Riley, Erlanger

John W. Somerville, Maysville

Ben F. Roach, Midway

Dona'd L. Graves, Frenchburg

Garnett J. Sweeney, Liberty

Grady Stewart, Olive Hill

Carl Pigman, Whitesburg

George M. Asher, Pineville

SPEAKER HOUSTON: The report is referred to Reference Committee No. 4.

The report of the Advisory Committee on School Health, Dr. Harvey.

**REPORT OF THE SCHOOL HEALTH
COMMITTEE TO THE
1952 SESSION OF HOUSE OF DELEGATES**

The School Health Committee was appointed a short time before the Annual Meeting and has therefore not been able to draw up a program and implement it, due to the time factor.

However, the chairman of the committee has done a considerable amount of exploratory and preliminary work. He has met with the Director of the Division of School Health of the State Department of Health and the Director of Health Education of the State Department of Education in an effort to become familiar with the program and work.

A full meeting of the Committee has been scheduled early in November to which interested officials of the State Department of Education and State Department of Health, along with officers of the State Medical Association and A.M.A. will be invited.

The School Health Committee feels that it has a broad field for service in the promoting of better health among the school population of this state and seeking a better understanding between the medical and teaching profession. It plans a continuing study of present program and methods of improving it in the future.

Respectfully submitted,

SCHOOL HEALTH COMMITTEE

/s/ Daryl P. Harvey

Daryl P. Harvey, Glasgow, Ch'mn.

H. B. Mack, Pewee Valley

Carl Grant, Winchester

Walter O'Nan, Henderson

D. G. Miller, Morgantown

Carl Pigman, Whitesburg

W. E. Hoy, Ashland

William J. Temple, Covington

SPEAKER HOUSTON: The report is referred to Reference Committee No. 4

The report of the Advisory Committee on Syphilis Control, Dr. Bloch of Louisville.

**REPORT OF ADVISORY COMMITTEE ON
SYPHILIS CONTROL TO THE
1952 SESSION OF HOUSE OF DELEGATES**

The three members of this committee agree that since it has performed no useful function since its establishment and can see no prospect for any work in the future, it would best be disbanded.

Respectfully submitted,

ADVISORY COMMITTEE ON
SYPHILIS CONTROL

/s/ Oscar Bloch, Jr.

Oscar Bloch, Jr., Louisville, Ch'mn.

Carey C. Barrett, Lexington

William Lamb, Louisville

SPEAKER HOUSTON: Dr. Bloch is not here. His report is here. It is being referred to Reference Committee No. 4.

The report of the Advisory Committee on Tuberculosis, Dr. Woodson of Louisville.

**REPORT OF THE ADVISORY COMMITTEE
ON TUBERCULOSIS TO THE
1952 SESSION OF HOUSE OF DELEGATES**

The following recommendations of the Committee on Tuberculosis are submitted.

The Committee met at 4:30 P. M., July 25, 1952, at 316 Francis Building, Louisville, Kentucky. Present: T. Ashby Woodson, M.D., E. R. Gernert, M.D., P. M. Crawford, M.D., Absent: Edward J. Murray, M.D., L. O. Toomey, M.D., and C. C. Howard, M. D.

Your Committee notes that in 1951 there were 1,017 deaths from tuberculosis in Kentucky with an annual death rate of 33.8 per 100,000 population. The relative position of Kentucky has not improved with respect to tuberculosis mortality. This disease continues to lead all other infectious diseases as a cause of death.

Comments and suggestions on the tuberculosis problem, submitted by physicians at the invitation of the Chairman, were reviewed. One comment mentioned the inadequate number of hospital beds for tuberculosis. Your Committee concurs, noting that with over 7,000 known active cases now on the Central Case

Register of the State Department of Health, there is less than one hospital bed per four such patients. A complaint in regard to fees for out-patient care at State Tuberculosis Hospitals was referred to Mr. J. D. Miller, Executive Director of the State Tuberculosis Hospital Commission. A suggestion for a council to advise on coordination of the programs of official and other agencies engaged in tuberculosis control activities was received. Your committee has been advised that the State Commissioner of Health has this matter under consideration.

The Committee has been informed that the Tuberculosis Hospital Commission will require case reporting on admission to the State Tuberculosis Hospitals of cases not previously reported. Your Committee congratulates the Tuberculosis Hospital Commission on this action, which insures more adequate tuberculosis reporting. Since reporting of tuberculosis is required by Statute your Committee believes that, except in emergency cases, there is little reason for any case not being reported prior to admission to the hospital.

The following recommendations are made:

1. HOSPITAL BEDS

Reliable information indicates that all State Tuberculosis Hospitals, particularly the new ones, could increase substantially the number of beds, by adding personnel and equipment, without construction of additional buildings. We recommend that the Kentucky State Medical Association register its approval of such tuberculosis hospital expansion, and submit to the Governor a draft of proposed legislation to implement such action.

2. TUBERCULOSIS CASE REPORTING

One reason for the inadequate number of hospital beds for tuberculosis at present is failure to report known cases, on the part of many physicians. Such neglect tends to minimize the actual need for additional beds. Knowledge of incidence, amount, and distribution of any communicable disease is essential to any public health measures for its control. We recommend that physicians be again reminded of the menace to the public health from either unknown or un-reported cases of active pulmonary tuberculosis.

3. SCHOOL EMPLOYEES

Existing Statutes do not require chest X-Rays as part of either the original or subsequent periodic physical examinations of school employees, although the practice of making use of them is quite general. The Statutes do not require termination of employment of school employees who develop active pulmonary tuberculosis. We recommend that the Kentucky State

Medical Association submit a draft of proposed legislation to require chest X-Rays as a part of all physical examinations of school employees, and to provide for immediate termination of service of any school employee found to have active pulmonary tuberculosis.

4. DIAGNOSIS OF TUBERCULOSIS IN SCHOOL EMPLOYEES

In the interest of both the public health and of protection of individual rights, disputed or doubtful diagnosis of pulmonary tuberculosis in school employees should be resolved as promptly as possible. We recommend that such individuals be referred for consultation to the State Tuberculosis Hospital Appeal Board, made up of the Medical Directors of all the State Tuberculosis Hospitals. We further recommend that in any individual disputed case, pending the next meeting of such Board, an interim decision as to the physical fitness of the individual for continued school employment be made by the Medical Director of the appropriate District State Tuberculosis Hospital.

Respectfully submitted,
COMMITTEE ON TUBERCULOSIS

/s/ T. Ashby Woodson

T. Ashby Woodson, Louisville,
Chairman

E. R. Gernert, Louisville

Edward J. Murray, Lexington

L. O. Toomey, Bowling Green

C. C. Howard, Glasgow

P. M. Crawford, Louisville

SPEAKER HOUSTON: The report is being referred to Reference Committee No. 4.

The Advisory Committee on the United Mine Workers Health and Welfare Fund, Dr. Fortune of Lexington.

REPORT OF ADVISORY COMMITTEE ON THE UMWA HEALTH WELFARE FUND TO THE

1952 SESSION OF HOUSE OF DELEGATES

DR. FORTUNE: It has been requested that the report be read. I will try to get through it as quick as possible.

Your Advisory Committee to the UMWA Health and Welfare Fund has conceived of itself as a liaison committee between the KSMA and the Medical Directors of the UMWA Health and Welfare Fund. We have considered our function to be threefold: 1) To adjust points of friction which may arise between practicing physicians and the UMWA Welfare Fund; 2) To inform itself as fully as possible concerning policy developments in the UMWA Welfare Fund and transmit this information to the Kentucky State Medical Society; and, 3) To advise with the UMWA Welfare Fund, when such

advice is invited, making such suggestions regarding policy as we believe to be in the best interest of good medical care with due regard to the interests of the practicing physicians of Kentucky. In this objective we have been greatly assisted by the enthusiastic cooperation of KSMA President, Clark Bailey, M.D., who not only attended the meetings of the committee, giving helpful information, advice and suggestions, but has also unselfishly devoted a great deal of his time between the meetings to the work of this committee. The Committee on Medical Care, J. B. Lukins, M.D., Chairman, met with this committee in Louisville on June 5, 1952, and representatives of that committee met with us in Harlan on August 2, 1952. The help of these committee members has proven of great value. Recognition should also be made of the three Area Medical Directors of the UMWA Health and Welfare Fund, having districts in Kentucky: Asa Barnes, M.D., of Louisville, John D. Winebrenner, M. D., Knoxville, Tennessee, and William H. Riheldoffer of Charleston, W. V. These directors have been most cooperative and frank in dealing with our common problem. We feel they have the same objective as we—the best available medical care for the coal mining districts of Kentucky. Any points of disagreement arise over the best means of attaining that mutual goal.

I. ADJUSTMENT OF INDIVIDUAL DISAGREEMENTS:

Several individual instances of friction between practicing physicians and the UMWA Welfare Fund were brought to the attention of the Committee, either by formal written report or by oral statement. The formal reports were acted on by the committee at its meeting in Harlan, and letters suggesting possible solutions were sent to the physicians involved and to the Medical Director UMWA Welfare Fund. The problems brought up in conversation were discussed at length with the Medical Directors, but formal action was not taken.

The particular phase of the work of the Advisory Committee is one which the committee considers highly important, and at the same time we feel somewhat dissatisfied with the method by which it is being handled. We feel that mutual trust is essential if the program is to develop in a manner satisfactory to both the medical profession and the UMWA Welfare Fund. Incidents of friction or disagreement should be promptly and thoroughly investigated, and in the light of facts obtained, solution of the problem suggested. Often this implies investigation in the territory where the disagreement exists. Since the committee is drawn from all parts of the state, frequent meetings, held often in remote sections of the coal field area, seem rather impractical. With

these facts in mind, the committee respectfully submits the following recommendation for consideration.

RECOMMENDATION FOR SUBCOMMITTEES ON PROFESSIONAL RELATIONSHIP TO UMWA HEALTH AND WELFARE FUND

1) There shall be set up in each Councilor District a committee to be nominated by the District Councilor. This committee shall be an investigating committee.

2) Instances of friction between the Fund and physicians may be referred to the Councilor District Committee representing the territory in which the physician concerned is practicing, or they may be brought directly to the attention of the Councilor District Committee by either the physician or the Area Medical Director of the U.M.W.A. Welfare Fund.

3) After ascertaining the facts from both parties the Councilor District Committee may make recommendations to the involved parties. It is felt that in most instances this will lead to a mutually satisfactory and prompt solution and the matter can be dropped.

I might say right here that these local committees are in force in some of the other states in which the UMW Welfare Fund is operated.

4) If a satisfactory solution cannot be reached, the District Councilor Committee shall forward the information it has gathered to the KSMA Advisory Committee to the UMWA Welfare Fund. This will be considered by the committee at its next meeting, or at a special meeting if the situation is urgent, and further attempts will be made towards a satisfactory solution.

II. CONSIDERATION OF PROFESSIONAL ABILITY OF PHYSICIANS

The Area Medical Directors of the UMWA Welfare Fund have expressed an interest in having set up a panel of specialists, which shall consider the professional qualifications of physicians in the state and advise whether they should be placed on the approved list of specialists for the Fund. The committee carefully considered this suggestion and feels that this is not a proper function of the Advisory Committee. We see no objection to the Area Medical Directors retaining specialists to advise them, but we feel that our committee should function as a liaison committee. We feel that any attempt to usurp governing functions over the profession is not only unjustified, but that it would also impair our usefulness to the profession and to the Fund.

III. MEDICAL PRACTICE IN THE COAL FIELD AREA

On Sunday, May 25, 1952 the Council on

Medical Service of the A.M.A. sent a survey team into the Coal Field Area. This team met with representatives of Tennessee, Kentucky and West Virginia at the Hotel Andrew Johnson in Knoxville. Kentucky was represented by KSMA President, Clark Bailey, M.D.; the Chairman of this Committee, Carl H. Fortune, M.D., and Mr. J. P. Sanford, Executive Secretary of the KSMA. At this meeting the whole problem of medical care in the coal field area was discussed. Particular discussion was given the proposed building of hospitals by the Memorial Hospital Association, an organization sponsored by the UMWA Health and Welfare Fund. It was also brought out that consideration is being given to the establishment of diagnostic clinics in the coal fields, sponsored by the same organization, although this plan is not crystalized.

Following this meeting the survey team spent the bulk of the next week visiting the coal fields and investigating medical care. During their stay in Kentucky they were accompanied by KSMA President, Clark Bailey, M.D.

At the committee meeting in Louisville on June 5th practically the entire day was given to discussion of this problem. The Area Directors: Asa Barnes, M.D., John Winebrenner, M.D., and William H. Riheldoffer, M.D., met with us and explained the purposes of the Fund and answered questions frankly and fully. The subject was further discussed at the meeting in Harlan on August 2nd. On September 6th and 7th, 1952 a meeting has been called in Charleston, W. Va., by the Committee on Medical Care for Industrial Workers of the Council on Medical Service, A.M.A. The members of our committee have been invited along with other representatives of the KSMA. A meeting of our committee is to be held during this session.

Your committee considers this problem of medical care in the coal mining area one of the most important confronting the profession in Kentucky today. We agree that in many sections of the coal fields, care is far from adequate. We further agree that the UMWA Welfare Fund has done much to improve this situation. We recognize that good medical care is practically impossible in certain areas because of lack of facilities and scarcity of physicians. We are sympathetic with the desire of the UMWA Welfare Fund to provide better diagnostic and hospital facilities in remote areas. At the same time we feel that the construction by the UMWA Welfare Fund of hospitals and diagnostic centers, which may well dominate medical practice in certain areas, introduces peculiar problems having a vital effect on the practice of medicine in Kentucky.

Your committee recognizes that a supple-

mentary report may be necessary after its meeting in September. Nevertheless, we have given much careful thought to this problem, and we feel that it is not out of order to state at this time certain conclusions we have reached and certain questions we have raised.

1) GENERAL PRINCIPLES:

In 1948 the Council on Industrial Health and Council on Medical Service of the A.M.A. made certain recommendations concerning the UMWA Welfare Fund which was then in its infancy. It is our feeling that in general these recommendations are still valid and with a few changes, additions and omissions, we present them as our attitude.

a) We believe the common purpose of the physicians of Kentucky and the UMWA Welfare Fund should be—

1) To make available the best medical and hospital care to the miners and their families.

2) To integrate the care furnished by the UMWA Welfare Fund with that provided by the local community.

3) To bring hospital facilities and medical care to isolated mine areas.

b) We believe that in the development of a medical program for the coal mining area certain general principles should be considered.

1) The development of new hospital and diagnostic facilities in the coal mining area should be carefully coordinated with existing facilities in the community. This might well include discussion with responsible members of the medical profession before definite sites are selected for construction of such new facilities. We believe the physicians of Kentucky could be helpful in the planning stage of a program which so vitally affects them.

2) A free choice of physicians and hospitals by the patient should be preserved in all communities where a choice can exist.

3) A fee-for-service of payment of physicians should be maintained except under unusual circumstances.

4) Control should be decentralized and the central organization should function only as a coordinating agency.

5) Physicians should remain free to practice in accordance with standards established by recognized medical agencies.

2) QUESTIONS RAISED CONCERNING MEMORIAL HOSPITAL PLAN

At the meeting in Louisville the Chairman was authorized to write to the Advisory Committee (A.M.A.) to the UMWA Welfare Fund and present certain questions which had arisen. The letter was answered by Dr. Warren Draper, Medical Director of the UMWA Welfare Fund. The questions are quoted below because the committee feels they are pertinent and because

we feel they have not been adequately answered. Our specific questions are:

a) Is it planned to have staffs of the hospitals open to all qualified and ethical physicians in the locality?

b) To what extent is it planned to preserve the fee-for-service relationship?

c) Is the free choice of physician by patient to be preserved—within the limits of ethical and qualified physicians?

d) To what extent will hospital staffs be salaried physicians or physicians on retainer fee of such size as to practically constitute full time work?

e) Is there being set up protection against coercion of physicians and nurses and other professional personnel to affiliate themselves with the UMWA, for instance, as members of District 50?

f) Is there planned any local board of management for the hospitals and centers, similar in a way to boards of trustees or other hospitals?

The committee realizes that it is probably impossible to fully answer these questions at the present time, but feels that they represent points to be considered.

RECOMMENDATION

On the basis of the information which it presently has, the committee recommends that no action be taken either endorsing or disapproving the proposed building of hospitals and diagnostic clinics by the Memorial Hospital Association.

3) HOME AND OFFICE CARE

At first the UMWA Welfare Fund provided home and office care, but this has been discontinued. At this point it should be emphasized that the UMWA Welfare Fund is not an insurance program. The miner makes no contribution and has no inherent right to certain services. The funds are provided by a royalty of 30 cents now 40c a ton on coal mined and such services are provided by the Fund as its Board of Trustees and Executive officers direct. Hence, the Fund has been within its right in discontinuing certain services which it feels it cannot or should not provide.

It is agreed by both the committee and the Fund Medical Directors that home and office care is in many, if not most, instances unsatisfactory. In some instances the company doctor and "check-off" system is in force. It is recognized that this system is unsatisfactory, both to physician and patient, but that it has been in many instances the only system by which any medical care could be provided. Elsewhere, the miner pays on a fee-for-service basis, but there are an inadequate number of available physicians. It is our opinion that lack of ade-

quate financial security is one important factor in discouraging physicians from going into these areas.

RECOMMENDATION

The committee recommends that the possibility of voluntary prepayment insurance to provide home and office care be studied by the appropriate committee of the KSMA.

V. POSTGRADUATE MEDICAL EDUCATION

It is agreed by the committee that lack of well trained medical personnel is an important cause of poor medical care in the coal field area. The lack of medical contacts and opportunities for keeping abreast with medical developments discourages competent young physicians from going into these areas. This same situation prevents physicians in remote areas from gaining new medical information as it becomes available.

The Committee on Postgraduate Medical Education KSMA has done excellent work in bringing postgraduate courses to the physicians of the state. It is recommended that especial attention be directed toward courses for general practitioners in the coal field areas. The Area Medical Directors of the UMWA Welfare Fund have indicated their willingness to cooperate fully in making such a program a success.

VI. SUMMARY OF RECOMMENDATIONS

1) Consideration is invited to the setting up of Councilor District Committees to promptly investigate differences between physicians and UMWA Welfare Fund and to recommend course of action.

2) No action, favorable or unfavorable, should be taken concerning the hospital and clinic building program proposed by the Memorial Hospital Association until more information is available.

3) Consideration is invited by the appropriate committee of the possibility of making prepaid voluntary insurance for home and office care available in the coal mining area.

4) The Committee on Postgraduate Education of the KSMA is invited to give special consideration to the physicians in the coal fields in planning its program of postgraduate courses.

Respectfully submitted,

ADVISORY COMMITTEE ON
UMW HEALTH AND WELFARE
FUND

/s/Carl H. Fortune

Carl H. Fortune, Lexington,

Chairman

C. D. Snyder, Hazard

Robert S. Howard, Harlan

Adam G. Osborne, Pikeville

Charles R. Yancey, Hopkinsville

George F. Brockman, Greenville

That was the situation as of August 15 when the committee's report was due.

On September 6th and 7th a conference was held in Charleston, W. Va., sponsored by the Committee on Medical Care for Industrial Workers of the Council on Medical Service A.M.A. This was attended by approximately 65 invited participants representing the A.M.A. central office, the U.M.W.A. Welfare Fund and the States of Virginia, West Virginia, Pennsylvania, Tennessee and Kentucky. The eleven participants attending from Kentucky included members of this committee, the President and President-Elect of the K.S.M.A., the Chairman of the Council, both delegates to the A.M.A., a representative from the University of Louisville and the executive secretary of the K.S.M.A. During this conference a meeting of the delegation was called to discuss points developed by the participants and certain recommendations were made to the conference. It was directed by this delegation that a supplementary report be made outlining certain points which it was felt should be brought to the attention of the House of Delegates.

The importance of the U.M.W.A. Welfare program in the whole picture of medical care was repeatedly emphasized. The importance to the physician in the coal mining area has already been stressed in the body of this report. It was developed in discussion that other labor unions are developing health and welfare programs, some of them along quite different lines than that followed by the U.M.W.A. Those who are guiding these programs are watching closely what is being done by the U.M.W.A. Welfare Fund and the relation of the physician to the program. In view of this, it is of utmost importance that the medical profession exert its influence toward guiding the expanding program of the U.M.W.A. Welfare Fund along lines which we believe to be in the best interests of the patient and good medical practice. We present below certain specific recommendations which we made to the conference and which were referred, along with recommendations from other states, to the Committee on Medical Care, A.M.A. for further study.

"The Kentucky delegation recognizes the need for better medical care in the coal mining area. We recognize the contribution toward this end made by the U.M.W.A. Welfare Fund. We are sympathetic with the desire of the U.M.W.A. Welfare Fund to further improve this situation. We also recognize the importance of better diagnostic and hospital facilities in the coal field district. It is hoped that the suggestions offered will stimulate discussion, which will be useful in attaining better medical care for these people.

(1) We strongly feel that preservation and strengthening of the general practitioner is essential to good medical care. We feel that competition between independent physicians makes for good medicine. With this in view we suggest an experiment in prepaid home and office care, to be conducted within a limited area. In carrying this out we further suggest:

a) That fee for service relationship and free choice of physician among qualified and ethical individuals be preserved.

b) That the program be financed by voluntary deduction from the miner's pay. Any deficit for the period of the experiment might be financed by the Fund.

c) Care for disabled miners and their dependents and pensioned miners and their dependents should be financed by the Fund. Successful good home and office care should materially decrease hospital care cost, so that this would not be an entirely uncompensated expense.

d) Any cases of abuse of the program by physicians should be referred to local liaison committees, or, if necessary to the State Liaison committee. Full cooperation by the medical profession will be essential for the success of such an experiment.

e) The selection of the location for such an experiment should be determined by the Medical Director of the Fund in cooperation with National and State Liaison committees.

(2) We suggest that hospital staffs be made open to qualified ethical physicians. Admissions to the staff and control of medical practice in the hospital should be a function of the professional staff.

(3) We recommend that the Fund consider contributions to supplement County Public Health Funds in coal mining areas in order to provide more public health education by public health nurses and improved sanitation through additional sanitarians.

(4) We believe, and strongly urge, that a period of at least a year should be given to study of our common problem and experimentation both by the Fund and by organized medicine in methods of improving medical care for the coal miner. We believe it would be a mistake for the A.M.A. to consider endorsement of the proposed hospital building program of the U.M.W.A. Welfare Fund and the Memorial Hospital Association without the background of this further study and experimentation."

The committee feels that the final recommendation given above is of utmost importance. The U.M.W.A. Welfare Fund is in a period of experimentation and expansion. Endorsement given now to the hospital building program contemplated by the Memorial Hospital Association would amount to endorsing a program,

the nature of which is not yet known. We feel that organized medicine should cooperate fully in working out a good program, but that it should not place its stamp of approval on a plan which is still in the formative stage and a plan which it may influence but cannot control. We, therefore, make the following recommendations:

(1) The House of Delegates of the K.S.M.A. shall consider the adoption of a resolution to read as follows:

"The physicians of Kentucky reaffirm willingness to accept their share of the responsibility for good medical care for the coal miner as well as for the rest of our citizens. We are not only willing but eager to work with the U.M.W.A. Welfare Fund in attaining the goal of better health and medical care in the coal mining area. We believe, and strongly urge, that a period of at least a year should be given to study of our common problem and experimentation both by the Fund and by organized medicine in methods of improving medical care for the coal miner. We believe it would be a mistake for the A.M.A. to consider an endorsement of the proposed hospital building program of the U.M.W.A. Welfare Fund and the Memorial Hospital Association without the background of this further study and experimentation."

(2) A letter including this resolution shall be sent to the Officers, Trustees and Delegates of the American Medical Association, in order to acquaint them with our concern over this important development in medical care.

Respectfully submitted,
ADVISORY COMMITTEE ON
UNITED MINE WORKERS
HEALTH AND WELFARE FUND
/s/Carl H. Fortune
Carl H. Fortune, Lexington,

Chairman

C. D. Snyder, Hazard
Robert S. Howard, Harlan
Adam G. Osborne, Pikeville
Charles R. Yancey, Hopkinsville
George F. Brockman, Greenville

SPEAKER HOUSTON: Thank you, Dr. Fortune. Gentlemen, you have heard this report, and it will be submitted to Reference Committee No. 4 for discussion.

The report of the Advisory Committee of the Woman's Auxiliary, Dr. E. Lee Heflin of Louisville.

REPORT OF THE ADVISORY COMMITTEE OF THE WOMAN'S AUXILIARY TO THE 1952 SESSION OF HOUSE OF DELEGATES

During the year, the Woman's Auxiliary to the Kentucky State Medical Association has

functioned so well under the leadership of Mrs. John Harter that the Advisory Committee was called upon in only one instance to render a small service.

The Health Education Committee of the Auxiliary, of which Mrs. Shelby Carr of Richmond, Kentucky, is the Chairman, planned and successfully executed a series of educational radio broadcasts in an effort to disseminate information and increase interest in sanitation and health in our rural districts. As members of the Advisory Committee, J. B. Lukins, M. D., and I attended two dinner meetings when the plans were presented, discussed and wholeheartedly approved.

The Advisory Committee wishes to express its thanks to Clark Bailey, M. D., for his interest and cooperation. The Chairman appreciated the privilege of serving the Association on this Committee.

Respectfully submitted,
ADVISORY COMMITTEE ON
WOMAN'S AUXILIARY
/s/ E. Lee Heflin
E. Lee Heflin, Louisville, Chairman
J. B. Lukins, Louisville
Hugh L. Houston, Murray

SPEAKER HOUSTON: The report is here, and it's been referred to Reference Committee No. 4 for study.

The report of the Committee on Scientific Exhibits, Dr. Pirkey of Louisville.

REPORT OF COMMITTEE ON SCIENTIFIC EXHIBITS TO THE 1952 SESSION OF HOUSE OF DELEGATES

Two formal meetings have been held, the first on February 28, 1952, at the Columbia Auditorium in Louisville, Kentucky, with all members of the Committee present except Charles B. Wathen, M. D., of Owensboro, Kentucky. Mr. Joe Sanford and representatives of the Jos. T. Griffin Company also attended. It was the feeling of the Committee that the rooms to the right of the main entrance would be adequate for the scientific exhibits.

Following this meeting, notices for the Exhibit were inserted in several issues of the Kentucky State Medical Journal and each scheduled speaker was contacted.

A second meeting was held on July 28, 1952, at the General Hospital. All members of the Committee were present except Woolfolk Barrow, M. D., of Lexington, Kentucky. Mr. Joe Sanford and representatives of the Jos. T. Griffin Company also attended this meeting. Eleven exhibits were selected and the exhibit spaces were allocated

The members of the Committee wish to thank our President, Clark Bailey, M. D.; our Secretary and General Manager, Bruce Underwood, M. D., and Mr. Joe Sanford, as well as the Jos. T. Griffin Company, for their splendid cooperation during the year, to make this Exhibit a success.

Respectfully submitted,
COMMITTEE ON SCIENTIFIC
EXHIBITS

/s/ Everett L. Pirkey
Everett L. Pirkey, Louisville,
Chairman

D. Woolfolk Barrow, Lexington
Harold Gordon, Louisville
Charles F. Wood, Louisville
Jesshill Love, Louisville
Charles B. Wathen, Owensboro

SPEAKER HOUSTON: His report is here, is being referred to Reference Committee No. 2, which is the standing committee.

The report of the Committee on Technical Exhibits, Dr. Carlisle R. Petty of Louisville.

REPORT OF COMMITTEE ON TECHNICAL EXHIBITS TO THE 1952 SESSION OF HOUSE OF DELEGATES

The spaces this year for the technical exhibits were bought rather than sold; our friends the exhibitors have certainly reacted favorably to the interest shown by our Kentucky physicians in their wares. Their evaluation report sent to the Medical Exhibits Association, a national organization, gave us a high rating—for which we are grateful.

We should like to again urge—with apologies for seeming repetition—that our members take the time to visit the exhibits, realizing that their presence, not only adds to the educational value of the meeting, but, finances it as well.

Again, we should like to acknowledge that the spade work together with the superstructure would have been impossible without the untiring efforts of Mr. J. P. Sanford. Unless one has had the opportunity to observe him and his office in action you cannot appreciate the tremendous amount of work and long hours entailed in making the arrangements necessary to keep everybody satisfied.

Our exhibitors are displaying products approved by the American Medical Association.

Respectfully submitted,
COMMITTEE ON TECHNICAL
EXHIBITS

/s/ Carlisle R. Petty
Carlisle R. Petty, Louisville,
Chairman
Edgar S. Weaver, Carrollton
James E. Hix, Owensboro

Clyde H. Foshee, Louisville
Arthur T. Hurst, Louisville

SPEAKER HOUSTON: Dr. Petty's report is here and being referred to Reference Committee No. 2 for study.

Report of the Conference of Presidents and Other Officers of State Medical Associations, Dr. Clark Bailey.

DR. BAILEY: The report has been filed.

REPORT OF CONFERENCE OF PRESIDENTS AND OTHER OFFICERS OF STATE MEDICAL ASSOCIATIONS TO THE 1952 SESSION OF HOUSE OF DELEGATES

The Conference of Officers of the State Medical Associations was held in Chicago, June 8, preceding the annual session of the American Medical Association. Outstanding speakers were: J. Stanley Kenney, M. D., of New York, President of the Conference; John M. Pattison, Presbyterian minister from Cheyenne, Wyoming; Alan B. Kline, President of the American Farm Bureau; Clarence Manion, author of "The Key to Peace" and Dean of the Notre Dame School of Law; and Walter H. Judd, M. D., Surgeon at Mayo Clinic and a member of the United States House of Representatives from the state of Minnesota.

Attending the meeting were Hugh Houston, M. D., Speaker of the House of Delegates of the Kentucky State Medical Association; Bruce Underwood, M. D., Secretary of the Kentucky State Medical Association and delegate to the American Medical Association; J. Duffy Hancock, M. D., delegate to the American Medical Association, and J. P. Sanford, Executive Secretary of the Kentucky State Medical Association.

All of the speakers were of national prominence and were forceful in emphasizing the danger of the trend toward socialism in our country and its menace to medicine. The increasing part that government plays in our individual and professional lives were stressed by each speaker. The responsibility of the doctor as a citizen "in this year of decision" is indeed great. It was an inspiration as President of your Association to attend this meeting.

Respectfully submitted,
/s/ Clark Bailey
Clark Bailey, Harlan, President

SPEAKER HOUSTON: The report is here and being referred to Reference Committee No. 2 for study.

Report on the Woman's Auxiliary, Mrs. John Harter of Louisville.

REPORT OF THE PRESIDENT OF THE WOMAN'S AUXILIARY TO THE KENTUCKY STATE MEDICAL ASSOCIATION TO THE 1952 SESSION OF HOUSE OF DELEGATES

To maintain our democratic way of life and uphold our "goodly heritage," to live by the Golden Rule in our homes, communities, our nation and the world, to support the high ideals and ethics of the medical profession, to work together for the health, well-being and understanding of our people—these are things worth striving for—and toward which members of the Kentucky Woman's Auxiliary have worked this year.

Our year began in October with honors for achievement in the past, when the Auxiliary presented a series of "living pictures" depicting the life of Dr. Ephraim McDowell and the story of his famed ovariectomy. The Southern Medical Auxiliary gave Kentucky a Doctor's Day program award for this tableau given for the Medical Association at its Centennial meeting. The Auxiliary marked a five-year project of refurbishing Dr. McDowell's house in Danville with a tea opening the house for the season on April 29. Some of the Auxiliary members wore costumes of the period.

In the field of health and health education Kentucky has continued the practice of reaching school children of every age group. Grammar school children in Clark County were participants in a thirteen-week radio quiz program sponsored by the State Auxiliary, with the approval and backing of the medical society. The script writing and technical work was carried on for the Auxiliary by the radio department of the University of Kentucky. The State Departments of Education and Public Health cooperated in providing material and making lesson plans and teaching arrangements. The material was broadcast from a Lexington radio station and was so successful that a second station requested the material and used it.

Senior high school students were reached by a cancer debate contest, with local county winners going to Lexington to the University of Kentucky for the finals. A tuberculosis essay contest was held in the junior high schools.

The college age group was reached by a publication contest on Americanism, under the direction of the public relations chairman. This was the second year for the contest, presented as an anti-socialistic and anti-communistic weapon. History books for the library were given for first place to Georgetown College and an American flag and standard for second place to the Journalism Department of the University of Kentucky for its new Journalism

Building.

The Auxiliary cooperated with the Kentucky Rural Health Council and was one of the sponsors of the First Kentucky Rural Health Conference.

The public relations chairman planned her work for the year with the thought that in a democracy such as ours, active participation of its citizens is required in government. Any project that touches the life of the community can succeed only when there is voluntary cooperative effort on the part of the people. The health of the community depends upon the vision of its citizens. Auxiliary members have been asked to take an active part in local drives for tuberculosis, March of Dimes, cancer, crippled children, Red Cross, Community Chest, heart, and the others. It is felt that every phase of our local programs, as well as our state-wide contests and projects, are contributory to good public relations. The chairman worked not only with the Auxiliary members, but through other organizations, such as D.A.R., P.T.A. and the colleges.

In legislation, besides continuing our efforts on the national level, Auxiliary members were active in the state during the legislative session and worked hard to help bring about the passage of the Hospital Licensing Act, the Titles Act and the Medical Practice Act. Efforts have also been made to get citizens to register to vote and to vote in the elections. They have been asked to judge all candidates for office by their stand on socialized medicine.

Most of the county auxiliaries cooperated in the work for civil defense, tuberculosis seal sales, blood banks, cancer mobile assignments, as well as all the drives for funds and support for the various health agencies.

Nurse recruitment has been actively promoted in most county auxiliaries, with several awarding nurse scholarships. On the state level, the first scholarship is being awarded this year.

As always, the State Auxiliary has promoted sale of subscriptions to the National Auxiliary Bulletin and to Today's Health. In the Today's Health contest this year Daviess and Muhlenburg counties placed well in their groups, with 245 and 218 per cent, respectively.

Our own news bulletin, The Blue Grass News, issued quarterly, appeared this year in a new format, four-page and full live news. It is a great help in getting information from the officers and chairmen to the members and in relaying interesting reports.

Membership this year was 793 members, including 52 members-at-large. There were 25 active auxiliaries, including new organizations in Warren and Pike counties.

The president attended two national A.M.A. meetings for state auxiliary presidents in November and the annual meeting in June; the Southern Medical Auxiliary in Dallas in November; the State Auxiliary Board Meeting and Conference of County Presidents and Presidents-Elect in Louisville in November; the spring board meeting in Lexington in March; meetings of seven county auxiliaries (Bowling Green, Harlan, Harrodsburg, Lexington, Louisville, Owensboro, Paducah); visited the McDowell House in Danville and the legislative session in Frankfort; and attended a regional meeting of A.A.U.W. in Birmingham.

It has been a pleasure and an inspiration to work with the members of the Auxiliary and the Medical Society throughout the state, in working together to further the ideals, the objectives and the projects of the two organizations.

Respectfully submitted,
WOMAN'S AUXILIARY TO THE
KENTUCKY STATE MEDICAL
ASSOCIATION
/s/ Margaret B. Harter
Mrs. John Harter, Louisville
President

SPEAKER HOUSTON: The report is referred to Reference Committee No. 2.

The report of the Board of Directors of the Kentucky Physicians Mutual, Inc., Dr. B. B. Baughman of Frankfort.

DR. BAUGHMAN: Mr. Speaker, the report is filed with the Secretary.

REPORT OF BOARD OF DIRECTORS OF KENTUCKY PHYSICIANS MUTUAL, INC. TO THE 1952 SESSION OF HOUSE OF DELEGATES

The President of the Kentucky Physicians Mutual, Inc. has the honor to report for the Board of Directors that the Corporation has had an excellent year. We have enjoyed remarkable progress for the third year of our existence.

Expansion of the plan has not been as rapid in the past year, but our financial stability is much better, and our coverage is quite satisfactory. We have pushed the sale of the individual contract throughout the state and, of course, have continued promotion of the group contract. We put into effect within the past year the revised schedule of indemnities with increased fees in many instances. We received much favorable comment on raising the medical fee from \$3.00 to \$5.00 a day and I find, by comparison, that ours is one of the highest fees paid by any of the plans in the United States for this service. We have recently ap-

proved and put into effect the payment of fees for the treatment of malignancy by x-ray and/or radium. We are now in the process of revising certain of the fees for eye, ear, nose and throat procedure, some of which have appeared out of line.

The President, along with the Executive Director and Assistant Secretary, had the opportunity to attend the National Blue Shield Convention held in San Francisco in April. Much valuable information was gained from this meeting, both from the formal talks which were heard, and from conversations with representatives of plans in most of the states. By comparison, it was found that in many instances our plans are keeping up with others, whereas we are behind in certain fields. From this meeting, two things appear obvious to us:

1. The urgent need for a service contract for people of low income.

2. The need for some means of payment for x-ray examinations, examinations of tissues, electro-cardiographic studies, and similar services rendered in a hospital.

We found that in a majority of states these services are paid along with the hospital bill by the Blue Cross. However, since the feeling of many Kentucky physicians is that all services performed wholly, or in part, by physicians should not be paid through a hospital but to the physician rendering the service, it would seem that a method must be worked out for Blue Shield to pay for these services. This problem was referred by the Council to the Committee on Medical Economics for study and recently it has been given a thorough study by the Medical Economics Committee, together with representatives from the Blue Shield. Out of this meeting, the Medical Economics Committee will make its recommendation to the Council. It is our earnest hope that a satisfactory arrangement can be made by which these services can be rendered and paid for.

Sales Promotion

On August 31, 1950, there were 43,386 individuals covered by our plan.

On August 31, 1951, there were 87,144 individuals covered by our plan.

On July 31, 1952, we find 134,920 individuals covered by our plan.

Your President stated last year that it was his goal that every county in Kentucky would be signed up by over 51% of the physicians as participating. We regret that this has not been accomplished. At the present time, we find 108 counties signed up but only one county, Jessamine, is not signed up, outside of the group of southeastern counties which are largely under the influence of some of the coal mining plans. These counties are: Breathitt, Floyd,

Lee, Leslie, Letcher, Magoffin, Martin, Owsley, Pike and Wolfe. Boyd County, of course, has had its own Blue Shield plan out of Huntington, West Virginia, for a number of years. We are well pleased with the coverage which we have obtained and we are gratified in some places where interest was lacking that the public, through the Farm Bureau and other agencies, has aroused the interest of the local medical profession in the Blue Shield. In many towns where people have had an opportunity to compare our plan with various commercial plans they are quick to see the advantages of a non-profit organization. The Blue Cross organization has continued to put on splendid drives on a high level of dignity and ethics in various parts of the state and hospitals are among our strongest supporters. We continue to solicit help of individual physicians in promoting our plan, because the people will readily listen to the advice of their physicians.

Financial Condition

The complete financial statement can be found in the attached statement as of July 31, 1952. Attention is called to the fact that a year ago the assets totaled \$393,470.21, of which \$100,000.00 was invested in Government bonds. At the present time, our assets total \$654,317.24, of which \$396,468.75 is invested in U. S. Government bonds.

Summary and Recommendations

Kentucky Physicians Mutual, Inc. is extremely proud of its record of its three years of existence. We have mentioned many of its accomplishments above. It has received some criticism, which has been duly noted, and we have attempted to make adjustments wherever possible. We are grateful for favorable comments, both from physicians and from the people.

We again urge that the physicians think in terms of the fee schedule for the people of low income.

We continue to seek the active support of the Medical Profession in Kentucky and we believe that by this support you are giving a positive answer to the not infrequent cries for socialized medicine.

We strongly urge that Kentucky physicians give support to the establishment of a service contract for low income groups. This will be given our careful study in the very near future.

We hope to make available to our people in the near future the payment for the services rendered in hospitals, which are not now covered by either Blue Cross or Blue Shield.

Since the term of the usual one-third of the directors (nine in number) expires this year, we

request that in accordance with the Articles of Incorporation that the House of Delegates submit eleven names for consideration by the Kentucky Physicians Mutual, Inc., in selection of seven physicians to fill the vacancies of the following: A. L. Cooper, M. D., Somerset; J. B. Lukins, M. D., Louisville; W. Vinson Pierce, M. D., Covington; J. G. Samuels, M. D., Hickman; Charles B. Stacy, M. D., Pineville; Bruce Underwood, M. D., Louisville and Branham B. Baughman, M. D., Frankfort.

Respectfully submitted,

KENTUCKY PHYSICIANS
MUTUAL, INCORPORATED

/s/ Branham B. Baughman
Branham B. Baughman, M. D.,
Frankfort, President

Officers

President, Branham B. Baughman, M. D.,
Frankfort
First Vice-President, T. O. Meredith, M. D.,
Harrodsburg
Second Vice-President, Mr. R. A. Dean, Louis-
ville
Secretary, Mr. Raymond F. Dixon, Louisville
Treasurer, Bruce Underwood, M. D., Louisville
Assistant Treasurer, Mr. Raymond F. Dixon,
Louisville
Executive Director, Mr. D. Lane Tynes, Louis-
ville
Medical Consultant, W. A. Blodgett, M. D., Lou-
isville.

Board of Directors

Name	Term Expires
B. B. Baughman, M. D., Frankfort.....	1952
A. L. Cooper, M. D., Somerset.....	1952
Mr. R. A. Dean, Sr., Louisville.....	1952
J.B. Lukins, M. D., Louisville.....	1952
W. Vinson Pierce, M. D., Covington.....	1952
J. G. Samuels, M. D., Hickman.....	1952
Charles B. Stacy, M. D., Pineville.....	1952
Bruce Underwood, M. D., Louisville.....	1952
R. W. Robertson, M. D., Paducah.....	1952
Ralph W. Allen, M. D., Pikeville.....	1953
William H. Cartmell, M. D., Maysville....	1953
Mr. H. J. Fenton, Murray.....	1953
Oscar O. Miller, M. D., Louisville.....	1953
Mr. W. Emmet Milward, Lexington.....	1953
Walter L. O'Nan, M. D., Henderson.....	1953
J. Vernon Pace, M. D., Paducah.....	1953
Samuel E. Paris, M. D., Bowling Green...	1953
Edgar S. Weaver, M. D., Carrollton.....	1953
Richard J. Rust, M. D., Newport.....	1954
J. Duffy Hancock, M. D., Louisville.....	1954
Coleman C. Johnston, M. D., Lexington...	1954
John Dickinson, M. D., Glasgow.....	1954

Joseph C. Bell, M. D., Louisville.....1954	Mr. S. A. Ruskjer, Louisville.....1954
Thomas O. Meredith, M. D., Harrodsburg..1954	Mr. J. E. Stanford, Louisville.....1954
Clark Bailey, M. D., Harlan.....1954	Mr. Raymond F. Dixon, Louisville.....1954

KENTUCKY PHYSICIANS MUTUAL, INCORPORATED
STATEMENT OF FINANCIAL CONDITION AS OF JULY 31, 1952

ASSETS

Cash—in Banks	\$245,561.61
Accounts Receivable	
Dues in Process of Collection	12,286.88
Investments	
U. S. Government Bonds	396,468.75
Total Assets	\$654,317.24

LIABILITIES

Blue Cross Hospital Plan, Inc.....	13,327.69	
Unreported and Unpaid Cases (Estimated).		
Surgical and Medical Benefits	137,000.00	
Future Maternity Benefits	100.00.00	237,000.00
Deferred Income		
Unearned Premiums	109,828.21	
Dues Paid in Advance	14,175.00	124,003.21
Total Liabilities		374,330.90

RESERVES

Unassigned Funds	279,986.34
Total Liabilities and Reserves.....	\$654,317.24

SPEAKER HOUSTON: The report is referred to Reference Committee No. 2 for study.

The report of the Board of Trustees of the Rural Kentucky Medical Scholarship Fund, Dr. Howard.

DR. HOWARD: The report is filed.

**REPORT OF BOARD OF TRUSTEES OF
RURAL KENTUCKY MEDICAL SCHOLAR-
SHIP FUND TO THE
1952 SESSION OF HOUSE OF DELEGATES**

The Rural Kentucky Medical Scholarship Fund is continuing to operate successfully and is accomplishing its intended purpose of providing more doctors for the rural areas of our state. Eighteen doctors who were aided by the Fund have graduated and entered practice in rural areas scattered over the entire state. The locations selected were satisfactory in each case to the Board of Trustees, to the graduate, and to local physicians. Some of these doctors have already repaid their loans and others are making payments on their indebtedness. As collections are received the Fund can rotate for many years to come.

The Fund now consists of \$154,048.00, of which

\$126,000.00 has been loaned to 70 students who have received a total of 174 individual loans. Ten graduates are now interning and will begin practice next summer. Of the remaining students, 10 are Seniors, 9 are Juniors, 12 are Sophomores, and 5 are Freshmen. Loans were made to five students who failed to complete their education and to one student who failed to enter rural practice after graduation.

Fifty-two of the students attended the University of Louisville School of Medicine and the remainder attended other schools.

It is estimated that all of the remaining unloaned funds will be required for students now in school during the remaining years of their education. For this reason, it was necessary for the Board to reduce the number of new loans during the current school year. Sixteen new applications were received, but ten had to be rejected. For the same reason it may not be possible to make any loans to new applicants for the 1953-54 school year unless funds are received from some source.

Many Kentucky physicians were very generous in contributing to the Fund when it was raised. Money is again needed, and if there are members of the Association who are inter-

ested in furthering this important phase of the Association's activities, their donations would be most gratefully received and would be used to help deserving medical students who are willing to practice in the rural areas of our state where their services are badly needed.

Respectfully submitted,

/s/ C. C. Howard

C. C. Howard, M. D., Chairman,
Board of Trustees Rural Ken-
tucky Medical Scholarship Fund

SPEAKER HOUSTON: The report is referred to Reference Committee No. 2.

We are ready for the report of the Medical Research Committee, Dr. Howard.

DR. HOWARD: The report is filed.

REPORT OF MEDICAL RESEARCH COMMISSION TO THE 1952 SESSION OF HOUSE OF DELEGATES

The Medical Research Commission has been functioning for four years. Their contract for medical research with the Medical School at the University of Louisville has been very satisfactory. It has improved their facilities for medical research and teaching in every respect and the School has been very cooperative and considerate of this fund. There has been an increase of medical students from the state at large. They now have one hundred students in their freshman class and eighty-five per cent of these are Kentucky boys and girls. This, we think, is very commendable.

We wish to express our deep gratitude to Governor Lawrence Wetherby and members of the Legislature for including in their budget the sum of \$425,000.00 to be used in the medical research program for each two years. This will be very helpful in many ways.

Respectfully submitted,

MEDICAL RESEARCH COM-
MISSION

/s/ C. C. Howard

C. C. Howard, Glasgow, Chairman
Bruce Underwood, Louisville
F. Guy Aud, Louisville
B. B. Baughman, Frankfort
Mr. E. H. Hackney, London

SPEAKER HOUSTON: Report is filed and referred to Reference Committee No. 2.

Report of the Centennial Committee, Dr. Sam Overstreet.

REPORT OF CENTENNIAL COMMITTEE TO THE 1952 SESSION OF HOUSE OF DELEGATES

The one remaining item of the Centennial Committee carried over from last year is the publication and sale of the Centennial Volume.

The task entailed a tremendous amount of work, editorially, which was done entirely by Emmet F. Horine, M. D. To him we wish to express the most sincere gratitude and congratulate him upon completion of the Volume of which we are all justly proud. It should be stated, furthermore, that Doctor Horine declined to accept the thousand dollar gratuity, which was awarded him by the Kentucky State Medical Association Council. This generous act has been most helpful in enabling your committee to complete this job satisfactorily from a financial standpoint.

Six hundred copies of this Volume have been printed. Three hundred and seventeen were sold and the money for these has been collected. That makes a total receipt in cash of \$1585.00. One hundred and ten have been ordered by eighty-four persons which have not been paid for nor delivered. Thirty-five complimentary copies have been distributed and one hundred and thirty-eight copies remain on hand. The printing cost of the books was \$2442.06. Our balance sheet, therefore, stands as follows:

317 copies sold and paid for @ \$5	
per copy	\$ 1585.00
110 copies in order not paid for.....	550.00
138 copies yet to be sold @ \$5 per copy	690.00
	<hr/>
Total Assets	\$ 2825.00
Cost of publication	2442.06
	<hr/>

Potential credit\$ 382.94

It is proposed that we arrange to put these one hundred and thirty-eight volumes on sale during the Kentucky State Medical Association Convention and make every effort to collect the outstanding amount due on the one hundred and ten copies already ordered. Your committee will proceed to accomplish this.

Respectfully submitted,

CENTENNIAL COMMITTEE

/s/ Sam A. Overstreet

Sam A. Overstreet, Louisville,
Chairman

Richard Slucher, Buechel

Clark Bailey, Harlan

William R. McCormack, Bowling
Green

J. Duffy Hancock, Louisville

Emmet F. Horine, Brooks

R. Haynes Barr, Owensboro

SPEAKER HOUSTON: The report is referred to Reference Committee No. 2.

SPEAKER HOUSTON: Are there any other resolutions or business of any nature that needs to be brought before this House of Delegates?

A VOICE: Is Dr. McDevitt going to introduce his motion he previously made?

SPEAKER HOUSTON: I have checked with the By-Laws and found that I have to have the motion in writing and so informed Dr. McDevitt to give us a copy. I don't know whether he cares to reintroduce it or not.

DR. McDEVITT: Whom do I submit this to in writing?

SPEAKER HOUSTON: To the Speaker of the House of Delegates in writing.

DR. McDEVITT: Right now? There's a time limit there.

SPEAKER HOUSTON: It's printed in your program, Dr. McDevitt. The Secretary says she will furnish you a stenographer.

DR. RICHARD G. ELLIOTT: I submit the following resolution:

Resolved:

1. That any award, prize or medal authorized by the Kentucky State Medical Association shall be donated by the Association.
2. That the award will bear a descriptive title: i. e. "Distinguished General Practitioner Award," "The Council Award for Distinguished Service," or the name of some distinguished deceased Kentucky physician whose accomplishments and service such an award would memorialize.

/s/ Richard G. Elliott

Richard G. Elliott, M. D.

Delegate, Fayette County Medical Society

SPEAKER HOUSTON: This resolution is being referred to Reference Committee No. 5 for study. Anyone wishing to discuss it will please report there tomorrow afternoon at two o'clock. The action of the House of Delegates will be taken on Wednesday evening.

Are there any other resolutions or new business?

DR. MILLER: I will try to make this as short as possible, because I have been up here too much tonight. The Delegates to the A.M.A. have touched on the fight that we have had to have the Blue Cross pay for the physical facilities in the rural physician's office, and this resolution deals with that.

RESOLUTION

WHEREAS, a considerable portion of the medical care in the rural areas are rendered in the offices of physicians:

NOW BE IT RESOLVED, that Blue Cross or similar hospital plans be approached by the advisory committee to make payments for physical facilities used in the physicians offices such

as x-ray, setting up trays to repair lacerations and cleaning up after fractures.

Respectfully submitted,

/s/ D. G. Miller

D. G. Miller, Jr., M. D.

Morgantown

The other one is much in the same line.

RESOLUTION

WHEREAS, a considerable portion of the medical care to veterans in rural Kentucky is rendered in the offices of the general practitioner,

WHEREAS, much of the plan of payment for their procedures is geared to hospital and specialist care,

NOW BE IT RESOLVED, that the President of the Kentucky State Medical Association appoint a committee authorized to renegotiate the contract with the veterans administration to allow adequate compensation for treatment by indicated illness.

Respectfully submitted,

/s/ D. G. Miller, Jr.

D. G. Miller, Jr., M. D.

Morgantown

SPEAKER HOUSTON: Do I understand there are two resolutions there?

DR. MILLER: Yes.

SPEAKER HOUSTON: I refer both the resolutions to the Resolution Committee No. 5 for study and action.

Is there any other resolution or new business?

I would like to make one or two announcements. The first one is out of an eligibility of 176, 29 Officers and 147 Delegates, we have 112 in attendance, 26 Officers and 86 Delegates.

Dr. Clark Bailey has an announcement.

DR. BAILEY: Mr. Speaker, and members of the House, Dr. Graves in his report failed to mention to you that the Committee on Scientific Assembly, recognizing the importance of the Civil Defense Program, has set aside two meetings emphasizing this whole matter. Many of us realize that within an area of 200 air line miles are three atomic bomb plants, and the men in the Pentagon tell us that we are in real danger of being bombed. It is rather important that we recognize this problem and that we doctors in the State really fulfil our obligation of being prepared in case of catastrophe. Tomorrow evening in this building will be the opening meeting program of the Association. This meeting has been dedicated to civilian defense. Colonel McDonnell, an officer who has just returned from the Utah flats, should give us an interesting program, and it is our hope

that we have a full attendance at that meeting.

Wednesday morning, the entire morning has been given over to this program including the importance of blood. There will be an officer back from Korea to tell us about how casualties are managed there, and other phases of the program will be discussed. I just wish to emphasize the importance of these two meetings and request your attendance.

SPEAKER HOUSTON: One other announcement, and that is about the Nominating Committees. You have two Nominating Committees to meet. One is the Delegates from the Councilor District No. 10. They are to meet and select their Chairman and that Chairman is to go with Dr. Trout, who is the Chairman of the General Nominating Committee, to the second session of our meeting tomorrow afternoon at two o'clock and make an announcement of their nomination. Dr. Trout and Dr. Davis and Dr. Stacy are the Nominating Committee, and they will meet to the right there tonight and listen to any suggestions the Delegates wish to make to them.

Is there any other business to come before the House tonight? If not, do I hear a motion to adjourn?

(A motion was duly made, regularly seconded, put to vote and carried.)

(Thereupon, at 11:00 p.m., the meeting was adjourned.)

SECOND SESSION

(Convened pursuant to adjournment at 7:30 p.m., October 8, 1952, at the Columbia Auditorium, Louisville, Kentucky, Dr. Hugh L. Houston presiding.)

SPEAKER HOUSTON: Will the House please come to order?

May I request that all the delegates and officers sit on this side of the aisle where you can be in the delegate section? I have asked the chairmen of the Reference Committees to please sit on the stand Dr. Howard has not come in.

It is the duty of your Speaker to call this, the second session of the House of Delegates Meeting to order for the year 1952

I wish to read from the instructions to aid us in our deliberations tonight.

"Discussions from the floor of the House for the second session are limited to five minutes on any one subject, except for such additional time as is granted by unanimous consent of the House. No new business can be presented at the second session of the House except with the approval of the council." Every effort will

be made to allow full consideration to each matter of business, but the cooperation of each member is requested in order that the business of the House may be expedited.

I will now ask the Chairman of the Credentials Committee if we have a quorum and are ready for business.

DR. MILLER: A quorum is present.

SPEAKER HOUSTON: We have a quorum. We are now ready for the business of the evening.

I would like the tellers of the first House of Delegates to serve me for this House of Delegates. They are Dr. Carlisle Morse, Louisville. Is he here?

THE FLOOR: He is on television.

SPEAKER HOUSTON: Dr. H. T. Wells, of Georgetown. Is he here?

Dr. Lawrence T. Hurt of Lexington. Is he here?

(No response.)

SPEAKER HOUSTON: As the three men are not here, we will ask three other men to serve. Is Dr. T. L. Carter of Tompkinsville here?

Is Dr. Bernard Popham—is he here?

Dr. Gladys L. Rouse. Will you act as a teller, please?

Dr. C. B. Stacy from Pineville here?

I am going to skip Dr. Rust because he has a duty on the stage.

Is Dr. Erwin Asriel here?

Is Dr. Joseph Schickel here? Thank you, sir. Will you please serve?

Is Dr. Perry Overby here?

Dr. James E. Winter from Louisville here? Dr. Winter please?

Will you three serve as tellers tonight?

We are now ready for the final report of the Council from Dr. Clyde C. Sparks of Ashland. Dr. Sparks.

DR. SPARKS: Mr. Speaker, members of the House of Delegates: Your Council has two items of business. First I would like to make an informal motion.

I move you, Mr. Speaker, that the House of Delegates of this association thank the officers of it and the Committees that have been charged with arranging and putting on this good meeting and that we authorize all payment of expenses incident to having this meeting.

SPEAKER HOUSTON: I have a motion. Do I have a second?

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. SPARKS: Mr. Speaker, your Council recommends in its final report that the business of the evening be conducted in executive session.

SPEAKER HOUSTON: I have a motion. Do I have a second to that motion?

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. SPARKS: This completes the term of duty of this Council as organized, and the Council through me, acting as Chairman, wishes to express its appreciation for the confidence of the House of Delegates during the past year.

Gentlemen, last Monday evening I spoke to you concerning the fact that this is not my Council or the members of the Council's council, but it is yours, and you are the delegates of your local areas. Your problems should become our problems in order that the Council may serve you better, and I plead with you with all the sincerity that I can command, that we follow that sort of practice in the next year. If you give your Council that kind of cooperation, you can alleviate and keep down many, many questions of dissension that may arise, and I believe sincerely that is the best way to do it.

I have enjoyed being on your Council this year.

SPEAKER HOUSTON: Thank you, Dr. Sparks.

It is now the duty of the Speaker to ask all visitors, all press representatives, and all persons except duly elected delegates and officers of the Association and members of the Kentucky Medical Association to leave the executive session of this House.

(Whereupon, the visitors left the room.)

(Reports of the Officers, Councilors and Council referred to Reference Committee No. 1 were approved by it and accepted by the House. On another issue considered by Reference Committee No. 1, the House of Delegates authorized the following statement: "The House of Delegates took no action on the application for a charter for a society of Negro physicians.")

SPEAKER HOUSTON: We will now go to the report of Reference Committee No. 2. The personnel of that Committee is Dr. W. Vincent Pierce, Chairman; Dr. Richard G. Elliott, Vice Chairman; Dr. John W. Meredith, Dr. Robert A. Orr, Dr. Price Sewell, Jr.

We will hear from Dr. Pierce.

DR. PIERCE: Mr. Speaker, members of the House of Delegates:

Your Reference Committee No. 2 wishes to report on the following reports of the standing committees:

The first was the report of the Committee on Arrangements. Your Reference Committee wishes to express their satisfaction with the arrangements and the meeting place. A suggestion is made that the Annual Banquet not

be held on the evening of the last day of the meeting because many doctors are unable to afford the additional time required for attendance.

Mr. Speaker, I recommend the adoption of the report as submitted.

SPEAKER HOUSTON: You have heard the motion. Do I have a second?

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: The report of the Committee on Scientific Assembly:

The Reference Committee accepted the report of the Committee on Scientific Assembly and recommends that at future meetings more papers be devoted to the diseases of children, which constitute a large part of general practice, and also recommends that guest speakers be placed on the program at the time when the maximum attendance may be expected.

Mr. Speaker, your Committee recommends the adoption of the report as amended.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: The report of the Public Relations Committee:

The report of this Committee was discussed and approved, and its accomplishments during the past year are most laudable in its achievements of good citizenship, good public relations and good service to the people.

Mr. Chairman, I move the adoption of the report as submitted.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: The report of the Committee on Medical Service.

Reference Committee No. 2 wishes to compliment the Chairman, Gaithel Simpson, and his committee on a most careful and comprehensive report. The Reference Committee is in agreement with the Medical Service Committee in that a survey, that is to say, a spot check, should be made of medical indigents in Kentucky as a basis of securing necessary funds from the General Assembly. The Reference Committee agrees that Blue Cross and Blue Shield coverage should be broadened. This additional coverage includes diagnostic x-rays with possibly some limitation, tissue studies, EKG and anesthesia. The Committee recommends the deletion of the second paragraph in Section 2 of the report, which reads as follows:

"This Committee would like to recommend for your consideration a plan of full coverage to be offered jointly by the profession and the

hospitals of Kentucky through their respective plans, Blue Shield and Blue Cross."

Under Section 3 of the report, entitled "Veterans Administration Hospital Program," the Reference Committee wishes to add resolution No. 5 which reads as follows:

"WHEREAS, a considerable portion of the medical care to veterans in rural Kentucky is rendered in the offices of the general practitioners;

"WHEREAS, much of the plan of payment for their procedures is geared to hospital and specialist care;

"NOW BE IT RESOLVED, that the President of the Kentucky State Medical Association appoint a committee authorized to re-negotiate the contract with the veterans administration to allow adequate compensation for treatment indicated by illness."

The Veterans Administration is requested to liberalize its fees paid to the private physician who is treating veterans on a fee basis. It requests that such fees be broadened so that these fees will be more equal to those fees paid to the physician by his private patients. That is, instead of the standard fee being \$3 for the initial visit and \$2 for subsequent visits, it should be \$5 for initial visits and \$3 for each subsequent visit.

Mr. President, I recommend the adoption of the report as amended.

SPEAKER HOUSTON: Do I have a second? (The motion was regularly seconded.)

SPEAKER HOUSTON: Any discussion?

DR. SPARKS: Mr. Speaker and members, the Council has asked me to speak to this for one particular reason—two reasons, I should say. This problem is a nationwide problem as far as the Veterans Administration is concerned. It has been a very hard difficult problem to handle and the American Medical Association in some respects has shied off from it on a few occasions. However, at the moment this problem is before the Board of Trustees and since this is a national problem it might be well to wait a while and see how the problem is going to be adjusted to a national level.

This afternoon we were approached as an organization through their President and President-Elect by the State level of the American Legion who stated in no uncertain terms, and they were extremely cooperative in their approach—not arrogant in any sense; they realize very thoroughly that there are many deficiencies and many discrepancies in the Veteran's care, not to the extent that he didn't get care, but they are very familiar with some of the many abuses to which it is used in connection with veterans' care.

Considering all this, your Council has directed me to make a substitute motion deleting the part of this report concerned with the Veterans Administration with the exception of Item No. 5, and that a committee appointed by the President of the Association work in connection with the American Legion of Kentucky who have been our friends, and see if some rational solution cannot be arrived at.

Thank you, Mr. Speaker.

SPEAKER HOUSTON: Do I have a substitute motion?

DR. PIERCE: I should like the privilege of canvassing those of the Committee who may be present and asking their permission to withdraw this portion of the report which would obviate the necessity for a substitute motion. Is that granted?

SPEAKER HOUSTON: Yes.

DR. PIERCE: I should like to ask each of the members here of their willingness that that be done.

DR. ELLIOTT: Yes.

DR. MEREDITH: Yes.

DR. ORR: Perhaps I didn't understand Dr. Sparks' statement. Did I understand him to say to delete all of that part of the report? All of the part about the Veterans Administration except Section 5?

DR. SPARKS: I believe that is correct. Let me check the number.

DR. ORR: In other words, so the House of Delegates will understand, Section 5 pertains to increasing or recommending an increase in fees that the Veterans Administration pays.

DR. SPARKS: The Council at no time wishes to interfere with the discussion of fees. (Laughter.)

DR. PIERCE: Dr. Orr, did you consent to the withdrawal?

DR. ORR: Yes.

DR. PIERCE: I make a motion, then, Mr. Speaker, that the report be withdrawn.

DR. MILLER: I believe that his report should be given in sections. There are too many sections of it to be voted on to vote on it as a whole.

SPEAKER HOUSTON: Any other discussion on this report?

DR. MEREDITH: One point, they probably had the possibility in mind that the payments for extension of service which is specified here, they hope to increase the payments and include such services as EKG and pathology and limited x-ray service. That's in the immediate future, they hope. I wish to raise a question as to whether that should be administered through Blue Shield, the physicians, or whether it should be paid to the hospitals through Blue Cross.

DR. ORR: I believe that Dr. Meredith is in error there. He is thinking of another section of the report. This section of the report pertains entirely to the Veterans Administration, its hospitals, and the relationship between the Veterans Administration and the private practice of medicine.

SPEAKER HOUSTON: Thank you, Dr. Orr. Dr. Miller made a motion. I don't know whether it is necessary or not to take it in parts, but does he have a second?

(The motion was regularly seconded.)

SPEAKER HOUSTON: All in favor of having Dr. Pierce's report taken in separate parts say "Aye."

THE FLOOR: "Aye."

SPEAKER HOUSTON: All in favor of accepting the motion as a whole say "No."

(No response.)

DR. MILLER: Mr. Speaker.

SPEAKER HOUSTON: Go ahead.

DR. MILLER: The manual says that these reports would be given one by one. You have some controversial issues there, and it seemed to me the one pertaining to the Veterans Administration contract, there is no mention of re-negotiating it with the Veterans Administration who always refer to their contract with the Kentucky State Medical Association in the matter of fees.

DR. PIERCE: If I may be allowed to say, my impression is that we have agreed to ignore entirely any change in the report as submitted regarding the Veterans Administration. As the report is now submitted, the only change which has been made is that this paragraph has been deleted which I will now read, which does not pertain to Veterans Administration.

DR. MILLER: How about Blue Cross and Blue Shield? They are separate.

DR. PIERCE: The report we are deleting is the one we are interpreting to mean we will favor a service-type contract.

"This Committee would like to recommend for your consideration a plan of full coverage to be offered jointly by the profession and the hospitals of Kentucky through their respective plans, Blue Cross and Blue Shield."

Our only recommendation of change as it now stands is that this paragraph be deleted.

Mr. Speaker, I move that the report as amended be accepted.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: The report of the Committee to study the Constitution and By-Laws:

Reference Committee No. 2 wishes to call attention of the House of Delegates to the fol-

lowing reason for suggesting change in the Constitution and By-Laws:

"Section (5)—During the last session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which by ballot the House of Delegates shall select five names to serve as the nominating committee for the next year. The five names receiving the most votes shall form the committee. The Committee shall select one of its members as the chairman. The Nominating Committee shall submit its report in writing to all members of the House of Delegates at the first meeting of the House of Delegates and shall submit one or more names for each officer to be elected. Additional nominations may be made from the floor by submitting the nomination without discussion or comment."

This change provides for a nominating committee selected by the House of Delegates. For this reason it is recommended that the Speaker of the House of Delegates "be authorized and instructed to appoint a committee of three members to determine by lot which of the following councilor districts—1, 2, 3, 4, 7, 9, 11, 12, 13 and 14—shall elect councilors at the 1953 Annual Session for the following terms: Five for three years; four for two years, one for one year. Provided, however, that all councilors shall be elected thereafter for full three-year terms as provided by Chapter 5 Section 1, of the By-Laws. Provided that councilors elected for one and two year terms shall thereafter be eligible for a full three year term."

We have included this much of the report in our Committee report in order that there would be no misunderstanding as to what is proposed.

Mr. Speaker, I move that the report as submitted be adopted.

(The motion was regularly seconded.)

SPEAKER HOUSTON: Any discussion?

DR. SMITH: I'd like to ask, Mr. Chairman, how that nominating committee is selected.

DR. PIERCE: "The Speaker of the House of Delegates shall submit to the House of Delegates a list of ten names from which by ballot the House of Delegates shall select five members to serve as a nominating committee for the next year." These five men will have the decision as to which will be for five or three or two year terms, or two or three or one, I should say.

SPEAKER HOUSTON: Any further discussion?

(No response.)

SPEAKER HOUSTON: Are we ready for the question?

(The motion was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: Report of the Medico-Legal Committee:

The Medico-Legal Committee has had a light year. Two suits were filed this year and five cases were compromised by insurance companies. Burns with fluoroscope, violet-ray and so forth, have increased and the committee recommends more emphasis in teaching x-ray to medical students. Doctors are urged to report any threatened suit promptly.

Mr. Speaker, I move the adoption of the report as submitted.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: The report of the Committee on Scientific Exhibits:

The Reference Committee wishes to compliment the Committee on the excellent work which they did and to recommend that the report be accepted as submitted.

I so move, Mr. Speaker.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: Report of the Committee on Technical Exhibits:

The Reference Committee recommends that the report be accepted as submitted and wishes only to emphasize the request of the Committee that all members take time to visit the exhibits.

I so move.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: The report of the Centennial Committee:

The Reference Committee accepts the report of the Centennial Committee to the 1952 Session of the House of Delegates and wishes to bring before the House of Delegates the recommendation that recognition is due Dr. Emmet F. Horine who was solely responsible for the editing of this Volume which was done without financial reimbursement to Dr. Horine.

Mr. Speaker, I move the adoption of the report as submitted.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: The report of the President of the Women's Auxiliary:

The report of the President of the Women's Auxiliary indicates that an active and productive year's work was experienced by the Auxiliary. Among these activities was a radio quiz program on health education for grammar school children; cancer debate contest for high

school seniors, and other health essay contests; active participation in rural health councils; "March of Dimes" drives, and so forth. The Auxiliary members also participated in civil defense work, blood banks, legislative work, and many other important activities affiliated with health matters.

The list of the President's activities indicates that she has spent an extremely busy and profitable year. The Reference Committee feels that an expression of appreciation from the House of Delegates to the Women's Auxiliary should be made.

Mr. Speaker I recommend that this report as submitted be adopted.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: The report of the Board of Directors of Kentucky Physicians Mutual:

The report of the Board of Directors of Kentucky Physicians Mutual indicates continued growth during the past year. As of July 1, 1952, approximately 135,000 individuals were covered by the Blue Shield indemnity contract. The total assets of the organization at that time were \$654,317, with unassigned reserves of \$280,000. This favorable experience has already resulted in broadened coverage, especially as relates to x-ray and radium therapy for certain malignant conditions.

The Reference Committee wishes to call attention to the suggestion contained in the report that the House of Delegates give consideration to the development of a service-type of contract for low-income groups. The Reference Committee feels that this does not represent either the unanimous opinion of the members of the Board of Directors of Kentucky Physicians Mutual or of the members of the House of Delegates and recommends that this statement be deleted from the report.

The terms of the following members of the Board of Directors expire in 1952:

Dr. B. B. Baughman, Frankfort; Dr. Arthur L. Cooper, of Somerset; Dr. J. B. Lukins, of Louisville; Dr. W. Vincent Pierce of Covington; Dr. J. G. Samuels, Hickman; Dr. Charles B. Stacy of Pineville; Dr. Bruce Underwood of Louisville; and Dr. R. W. Robertson of Paducah.

The following names are submitted to the House of Delegates for nomination, from which the Board of Directors will select seven physicians to serve on the Board of Directors for three years each:

Doctors Baughman, Cooper, Lukins, Pierce, Samuels, Stacy, and Underwood and Dr. Robertson; and the additional four names of Dr. Robert L. Rice, Dr. William E. Davis of Mid-

dletown, Dr. Frank Duncan, Monticello. I beg your pardon, there are only three additional names.

Mr. Speaker, I move that the report as amended be accepted.

(The motion was regularly seconded.)

SPEAKER HOUSTON: Any discussion?

A VOICE: I'd like to get the one part on the Physicians Mutual clarified. I didn't quite understand about the paragraph you were going to delete. Will you please read it again?

DR. PIERCE: In the original report which was submitted, I will read the paragraph in question from the written report, if I may. I quote:

"We strongly urge that Kentucky physicians give support to the establishment of service contracts for lower-income groups. This will be given careful study in the near future."

The Reference Committee has taken the attitude that this does not represent the unanimous opinion of the Board of Directors of Kentucky Physicians Mutual, and recommends that that paragraph be deleted from the report.

A VOICE: Just a point of information. Dr. Rice has closed his office and is not practicing medicine anymore, indefinitely.

DR. PIERCE: That reduces the number of names submitted then to ten instead of eleven. The by-laws call for eleven. If we remove this name from the list, that will reduce it to ten and will call for nominations from the floor which will further delay our proceedings for the evening. It has been suggested by the Chair that his name be left on and he will not be named as a member of the Board of Directors.

Mr. Speaker, I move that the report as amended be accepted.

(The motion was regularly seconded, was put to vote and carried.)

DR. PIERCE: Next is the report of the Board of Trustees of the Rural Kentucky Medical Scholarship Fund.

This report was carefully considered and approved. It should be noted that due to lack of funds it may not be possible to make any loans to new applicants during 1953 and 1954. It is therefore recommended that the physicians become more generous in their giving so that this important fund and function may be carried on.

Mr. Speaker, I move that the report as submitted be adopted.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: The report of the Medical Research Commission:

This report is accepted and the Commission is commended for the success of its efforts. The Reference Committee commends Governor

Lawrence Wetherby and the State Legislature for their interest in and support of this program.

Mr. Speaker, I move that the report be adopted as submitted.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PIERCE: Mr. Speaker, I move the adoption of the report as a whole as submitted.

(The motion was regularly seconded, and put to vote and carried.)

SPEAKER HOUSTON: So ordered. Thank you, Dr. Pierce.

We are now ready for the report of Reference Committee No. 3. The personnel is Dr. Richard J. Rust, Newport, Chairman; Dr. Gracie R. Rowntree, Louisville, Vice Chairman; Dr. Keith P. Smith, Corbin; Dr. B. Ralph Wilson, Sharpsburg; Dr. John P. Glenn, Russellville. Dr. Rust will make the report.

Dr. Pierce wishes the floor for a minute.

DR. PIERCE: I think there has arisen some misunderstanding about the Committee on Medical Service, the report of the Committee on Medical Service, and I feel this should be clarified, and that there will be no mistake made. My understanding was that the only deletion was the resolution in regard to fees. Dr. Sparks is under the understanding that the whole veterans discussion was withdrawn from the report.

DR. SPARKS: May I speak?

Mr. Speaker, the motion I made as a substitute motion stated that in the report of the Committee on Medical Service that that portion of it dealing with the Veterans Administration with the exception of No. 5 be deleted.

DR. ORR: I think that is entirely correct. Section 5—Dr. Pierce, will you read Section 5 that was added so that they will understand this?

DR. PIERCE: I have been under complete misapprehension on this thing and so stated to the House. I was under the impression that the Section which we added was O. K.'d and all the rest of the reference to the Veterans Administration they wished withdrawn.

DR. ORR: Sections 1, 2, 3, and 4 are withdrawn under the Section of Veterans Administration. Section 5 was kept.

DR. PIERCE: Is that the way the vote was registered?

SPEAKER HOUSTON: Yes.

DR. PIERCE: That's the way the motion was made so there is no misunderstanding about it.

DR. RUST: The report of the Kentucky Committee for the contribution to the American Medical Education Foundation:

It was agreed by the Committee to approve the report of the Committee in toto. It was further agreed that this Committee go on record as recommending:

(1) Referring back to the Council to determine the financial feasibility of the contributions by the State Association to this foundation.

(2) Recommend that an extensive program for private solicitation among the profession be instituted.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Diabetes Committee:

It was the feeling of the Reference Committee on this report that it be approved with special commendation for the excellent work of Dr. Carlisle Morse and his Committee in the carrying out of the work throughout the previous year. It is also recommended that official recognition by the House of Delegates of the Medical Association be sent to Ames Company of Elkhart, Indiana, for their assistance in supplying materials for the furthering of this work. It was recommended that the Publicity Committee investigate the feasibility of more thorough coverage of the publicity in the State with reference to the work of this Committee.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Advisory Committee to the Editor:

It is recommended that the report of this Committee be accepted and approved with thanks.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Education Campaign Committee:

After study of the report of the Education Campaign Committee, the following recommendations were decided upon:

(1) It was recommended that the House of Delegates concur in the opinion of this Committee that the practice of sending out the newsletter be continued and expanded.

(2) That the House of Delegates endorse the opinion of this Committee that serious and favorable consideration should be given by the faculty at the University of Louisville School

of Medicine to include in its course of study during the senior year a subject that might be called "Medical Manners and Public Service," in order to familiarize the students with the importance and the method of achieving proper public relations by the way the doctor conducts himself in the presence of the patient.

(3) That the House of Delegates approve the proposed program of education of medical secretaries in public relations as well as in the filling out of insurance forms, letters, and so forth.

(4) That the House of Delegates strongly urge the formation of an emergency call system by all county society groups.

(5) That the House of Delegates encourage the establishment of committees at the county level to a press radio medical code of relations in order to obviate misunderstandings between these various groups.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: The report of the Committee on Emergency Medical Service:

It was recommended that the report of this Committee be approved and that the State Medical Association do everything in their power to urge upon the various governmental agencies the necessity of securing the necessary financial help in order to establish adequate stock piles of medical supplies to be used in the event of disaster.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: The report of the Committee on Hospitals:

It was recommended that the report of this Committee be approved. That portion of the report dealing with the United Mine Workers of America Hospitalization program will be covered by the action of another Reference Committee

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Kentucky State Advisory Committee to Selective Service:

It is recommended that the report of this Committee be accepted and approved, in toto.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Kentucky State Medical Association Dental Committee:

It is recommended that this report be accepted and that an approval of the following points be made:

(1) That County Medical Societies and Dentists in the community have at least one joint scientific meeting every year, in which matters of mutual interest would be treated by a competent essayist.

(2) That some type of joint meeting (possibly including the wives and families of the physicians and dentists) of a social nature be held once a year.

(3) That physicians and dentists in the local community collaborate in the solving of local public health problems.

(4) That the dentists be asked to participate in all local Civil Defense plans.

(5) That the dentists be asked to participate and cooperate in the Diabetic Detection Drive held each November.

(6) That the dentists be asked to support the Rural Health Movement and cooperate with the physicians in sponsoring and providing leadership for such efforts.

(7) That physicians and dentists unite their efforts in attempting to get all persons involved in health service, including their own families and employees registered, and see that they vote in each election.

(8) That the two professions explore areas in which they could cooperate in solving public relations that might exist at the local level.

Mr. Speaker: I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: The report of the Kentucky State Medical Association Pharmacy Committee:

It is recommended that the report of this Committee be accepted and approved in its entirety.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Legislative Committee:

It is recommended that the report of this Committee be accepted and approved with thanks. It is deemed advisable by this Committee that the House of Delegates be given the report of the results of the activities of this Committee in toto.

"The primary concern of the Legislative

Committee during the past year was with the action of the regular 1952 Session of the Kentucky General Assembly. The Association sponsored no legislation at that session but gave active support to several bills sponsored by the Department of Health. Measures in that category, of the greatest interest to members of the Association, which were enacted into law, included the following:

"House Bill No. 137, known as the 'Medical Practice Act,' which is a comprehensive revision of the law regulating the practice of medicine and osteopathy.

"Senate Bill No. 50, referred to as the 'Hospital Licensure Bill,' which provided for the licensing and inspection of hospitals.

"House Bill No. 280, a professional titles act, which restricts the use of the title 'Doctor,' in connection with the practice of the healing arts, to persons holding degrees from authorized institutions and requires the designation of the particular degree held by such persons.

"Senate Bill No. 115, which permits the payment of salaries of physicians employed by State institutions in amounts not to exceed \$12,000 annually, thus removing the previous limit of \$7,000.

"Senate Bill No. 140 created a new and separate Department of Mental Health.

"House Bill No. 144 authorizes the State Board of Health to render technical assistance to local health departments and established a broad formula for the allocation of state funds to such units upon an equalization basis.

"An unsuccessful attempt was made to amend the Hospital Licensure Bill so as to exempt chiropractic hospitals.

"During the period before and during the Legislative Session, the Committee held numerous meetings and served as a clearing house for legislative matters.

"As a result of the year's work, this Committee is convinced that the success or failure of the Legislative Committee depends entirely upon the extent to which each individual member of the Association informs himself upon governmental affairs, particularly on the local level, and his participation in the election of qualified and honest public officials."

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

DR. RUST: Report of the Board of Directors of McDowell Memorial Foundation:

It is recommended that this report be accepted and approved. It is further recommended that the usual allotment of \$1500 be made by the Council for this foundation.

Mr. Speaker, I move the adoption of this

section of the report.)

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Committee on Medical Education:

It is recommended that the report of this Committee be accepted and approved. It is likewise further recommended that a continuation of the telephone postgraduate program be considered for continuation.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Special Committee on Medical Education:

It is recommended that this report be accepted and approved.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Medical Practice Committee:

It is recommended by this Reference Committee that this report be accepted and approved in toto.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: The report of the Medical School Advisory Committee:

It is recommended that this report be accepted and approved in toto.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: The report of the Committee on Nurse Training:

It is recommended that the report of this Committee be accepted and the approval of the House of Delegates of the six points made by this Committee:

- (1) Additional schools for graduate nurses.
- (2) Establish schools for practical nurses.
- (3) Introduce the use of medical clerks in hospitals all over the State, thereby relieving the nurses of clerical duties.
- (4) Establish training schools for orderlies, giving certificates after prescribed course is taken.
- (5) Establish schools for both graduate and practical nurses for colored people.

(6) Set up practical training program in mental and T. B. hospitals.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Professional Relations Committee:

It is recommended that the report of this Committee be accepted and approved in toto.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Committee on Training of Ambulance Attendants:

It is recommended that the report of this Committee be accepted and that the Kentucky State Medical Association recommend that each district medical society institute a program of training the ambulance attendants of their territory.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Report of the Committee for World Medical Association:

It is recommended that this report be accepted and approved.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. RUST: Mr. Speaker, I move the adoption of this report as a whole as amended.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

We are now ready for the report of Reference Committee No. 4. The personnel of that Committee is as follows: Dr. George W. Pedigo, Louisville, Chairman; Dr. Frank L. Duncan, Monticello, Vice Chairman; Dr. Leon Higdon, Paducah; Dr. T. O. Meredith, Harrodsburg; Dr. S. B. May, Eminence.

Dr. Pedigo will make the report.

DR. PEDIGO: Members of the House of Delegates, the report of Reference Committee No. 4, which is the report of the Advisory Committee on Medical Care.

The report of the Advisory Committee on Blood Banks, along with the supplemental report, have been received and studied. The principal recommendations are:

That the blood banks be supervised by licensed M. D. members of this Association;

That the members of the Association actively take part in the community banks on advisory committees;

That all blood banks in Kentucky be operated under regulations of the Biological Division, National Institute of Health;

That members of the Association assist in the recruitment of blood;

And, in view of the fact that blood transfusions are not entirely free of danger, that each case be carefully evaluated before a transfusion is given.

Mr. Speaker, I move that this report with the supplemental report be adopted as a whole.

(The motion was regularly seconded, was put to vote and carried.)

DR. PEDIGO: The Report of the Advisory Committee on Cancer has been received and studied. In this report are listed the different appropriations for cancer study, the educational program which has been in effect, and a list of cancer clinics over the State with their statistical reports.

Mr. Speaker, I move the adoption of this report as a whole.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory Committee on Crippled Children was received and studied. There was no meeting of this committee during the year of 1951-1952. The report covers statistically some of the work done by the Crippled Children Commission.

Mr. Speaker, I move the adoption of this report as a whole.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory Committee on General Practice was received. There has been no meeting of this Committee during the year, and nothing is reported at this time.

Mr. Speaker, I move the adoption of the report as a whole.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory Committee on Industrial Medicine and Surgery was received. The Kentucky Industrial physicians had one meeting during the year to discuss ways and means of promoting more interest in the whole field of industrial medicine.

Mr. Speaker, I move the adoption of this report as a whole.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory Committee on Mental Hygiene and Mental Institutions has been received and studied. It lists several advances of importance which have been made on behalf of mental patients in Kentucky since last year. The committee opposes a move to concentrate elderly people in one hospital and recommends repair of buildings which are in poor condition, and it recommends that a survey be made of the criminal insane section at Lakeland.

Mr. Speaker, I move the adoption of the report as a whole.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory Committee on obstetrics has been received and reviewed. This Committee feels that a thorough study of maternal deaths in Kentucky should be made. The last paragraph in their report states that an appropriation of two or three hundred dollars a year for printing and stamps by the Kentucky State Medical Association be made for the Committee. Since all appropriations must be approved by the Council, we recommend that this paragraph be amended by inserting at this point a recommendation that the Council consider the advisability of such an appropriation.

Mr. Speaker, I move the adoption of this report as amended.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER: So ordered.

DR. PEDIGO: The report of the Pediatric Advisory Committee has been reviewed by our Committee. This report primarily was a resume of a joint meeting of the Obstetrical Advisory Committee, the Division of Maternal and Child Health and the Pediatric Committee.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory Committee on Physical Therapy was reviewed, and since this Committee had no formal meeting during the year they had no report.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory

Committee on Rural Health was reviewed by the Committee. This report discussed the first Rural Health Conference held in Louisville May 7 and 8.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Committee on School Health was reviewed. This committee is a new committee and has not had time to draw up a definite program due to the time factor. The Chairman of the committee has done a considerable amount of exploratory work.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory Committee on Syphilis Control was reviewed. The members of this Committee have had no useful function since its establishment and recommend that their committee be disbanded. Our Committee recommends that this Committee on Syphilis Control be disbanded as requested.

Mr. Speaker, I move the adoption of this report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory Committee on Tuberculosis has been reviewed. This Committee has made several recommendations.

(1) Hospital beds. Reliable information indicates that all State tuberculosis hospitals, particularly the new ones, could increase substantially the number of beds by adding personnel and equipment, without construction of additional buildings.

(2) This committee recommends that the Kentucky State Medical Association register its approval of such tuberculosis hospital expansion.

(3) This Committee also urged all doctors to report all known tuberculosis cases so that the actual need for additional beds is fully realized. It was also recommended that all school employees have chest x-rays as part of their physical examination.

Our Committee recommends the acceptance of these recommendations.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory Committee on the Woman's Auxiliary was reviewed and we recommend the acceptance of this report.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: The report of the Advisory Committee on the United Mine Workers Health and Welfare Fund has been reviewed, and it is felt that Dr. Fortune and his Committee have done an excellent job with this problem. This problem was discussed in considerable detail by our Committee and a summary of the recommendations of Dr. Fortune's committee is as follows:

(1) Consideration is invited to the setting up of councilor district committees to promptly investigate differences between physicians and United Mine Workers Health and Welfare Fund and to recommend course of action.

(2) Consideration is invited by the appropriate committee of the possibility of making prepaid voluntary insurance for home and office care available in the coal mining areas. It would seem this problem could be referred to the Committee on Medical Care for their study during the next year.

(3) The Committee on Postgraduate Medical Education of the Kentucky State Medical Association is invited to give special consideration to the physicians in the coal fields in planning its program of postgraduate education.

Our Committee concurs in these recommendations and moves that they be accepted by the House of Delegates.

Mr. Speaker, I move that this section of the report be accepted.

(The motion was regularly seconded, was put to vote and carried.)

DR. PEDIGO: The supplementary report of the Advisory Committee on the United Mine Workers Health and Welfare Fund has recommended that the House of Delegates of the Kentucky State Medical Association adopt a resolution to read as follows:

"The physicians of Kentucky reaffirm willingness to accept their share of the responsibility for good medical care for the coal miner as well as for the rest of our citizens. We are not only willing but eager to work with the U.M.W.A. Welfare Fund in attaining the goal of better health and medical care in the coal mining area. We believe, and strongly urge, that a period of at least a year should be given to study of our common problem and experimentation both by the Fund and by organized medicine in methods of improving medical care

for the coal miner. We believe it would be a mistake for the A.M.A. to consider an endorsement of the proposed hospital building program of the U.M.W.A. Welfare Fund and the Memorial Hospital Association without the background of this further study and experimentation."

Our Committee recommends that this resolution be adopted by the House of Delegates.

Mr. Speaker, I move the adoption of this section of the report.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. PEDIGO: Mr. Speaker, on behalf of Reference Committee No. 4, consisting of Frank L. Duncan, Vice Chairman; Leon Higdon, T. O. Meredith, S. B. May, and myself as Chairman, we move the adoption of the report as a whole.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

We are now ready for the report of Reference Committee No. 5. The personnel of this Committee is as follows: Dr. Charles B. Stacy, Pineville, Chairman; Dr. Howell J. Davis, Owensboro, Vice Chairman; Dr. Coleman J. McDevitt, Murray; Dr. John D. Handley, Hodgenville; Dr. John W. Scott, Lexington.

Dr. Stacy has to be absent tonight and Dr. Howell J. Davis of Owensboro, Vice Chairman, will give the report. Dr. Davis.

DR. DAVIS: Mr. Speaker, members of the House of Delegates: This report contains five sections, and in some of the previous committee reports that we have had, I think three or four sections have already been covered.

SPEAKER HOUSTON: So ordered.

DR. DAVIS: Section 3 of this report, resolution by the delegate of Fayette County Medical Society, Richard Elliott:

(A) To limit awards, prizes and medals authorized by the Kentucky State Medical Association to those donated by the Association.

(B) To stipulate that all such awards bear a descriptive title or a name of some distinguished deceased Kentucky physician.

Mr. Speaker, the committee's action was unanimously "Yes" on this section of the report. I therefore move that this resolution be approved.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. DAVIS: Section 4. This is a resolution by the delegate from Butler County, D. G. Miller, to direct the President of the Kentucky State Medical Association to appoint a committee authorized to renegotiate the contract with the Veterans Administration to al-

low adequate compensation for treatment indicated by illness.

I believe this has been covered by Committee 2.

DR. MILLER: That was partially covered. I attempted to speak on that. There is no provision to negotiate it with the Veterans Administration and in discussing any disputes with them, they say, "We have a contract with your State Medical Association." That's the way it stands. So the State Medical Association will have to renegotiate this contract if there is any adjustment of fees recommended at the House of Delegates.

DR. DAVIS: Mr. Speaker, the action of the committee was unanimously to table this section of the report. I therefore move that no action be taken on this resolution.

(The motion was regularly seconded, was put to vote and carried.)

DR. DAVIS: Section 5. This was a resolution by the Delegate from Butler County, D. G. Miller, to have the Advisory Committee to Blue Cross to approach the Blue Cross Hospital Plan and similar hospital plans, urging them to make payments for the use of the physical facilities in physicians' offices.

Mr. Speaker, the Committee's action on this section of the report was unanimously "No." I therefore move that this resolution be disapproved.

(The motion was regularly seconded.)

SPEAKER HOUSTON: Any discussion?

DR. MILLER: I again got tied up with the two committees and couldn't be there. The sole purpose in asking this House of Delegates to approve Blue Cross paying for the physical facilities in our office as it would in the emergency room of a hospital is to allow us who are forbidden the use of hospitals by distance, and for those patients who can't afford to do it, pay for physical facilities of our offices. I have been offered a primary contract and turned it down because I thought it wasn't fair to me. If it wasn't fair for the rest of you physicians in Kentucky, it wasn't fair for me. I believe if the House of Delegates will affirm this principle that the Blue Cross will allow us to apply and allow us a doctor's office inspection and if they feel it satisfactory for emergency treatment, lacerations or fractures, that then they will pay the same fees as they pay the hospital. For that reason I ask that you vote "no" to the Reference Committee report so that those of us without hospitals may adequately treat our patients without having to take them considerable distance to the hospital.

DR. SCOTT: Mr. Speaker, it was the opinion of at least one member of that Committee that the Blue Cross with its members particu-

larly devoted to that subject and fully cognizant with it and composed of members of this association, could deal with that thing directly without action by the House. Certainly, the pro's and con's can be gone over more definitely with more knowledge by them than it could by us uninformed people, and that was one reason that I for one voted to disapprove the report, the resolution.

DR. GUDEX: I happen to be a general practitioner, and many other general practitioners out in the State have the same problem that Dr. Miller has. I am not speaking for myself but for the general practitioners who are not here tonight. We have to consider their problems. This has gone to the A.M.A. twice, and it has been turned down, or it hasn't been considered, as I understand it. The only way we can get any pressure to bear is for this body to do something about it. It depends on whether you as doctors want to do anything or whether you don't want to do anything. I think, speaking for the general practitioners of Kentucky, we have a point to try to get some money to pay for our expenses that we have under those conditions. Not for us general practitioners in the center. But the men out in the rural districts need our help. The least we can do is to go on record recommending it, and if we recommend it then we can go ahead and do something. If we don't do something, take an action in favor of these men like Dr. Miller, then they haven't a leg to stand on. They will do their emergency work and not be paid for it. Every man in this building should at one time or another have had that experience of taking care of an automobile accident, and maybe not one, but maybe seven or eight, and then they walk out and leave the dirty office and you have to spend your money for your penicillin and the antitoxin and everything else.

A VOICE: May I suggest, Mr. Speaker, that you make it clear what you are voting on?

SPEAKER HOUSTON: State the resolution and then your motion.

DR. DAVIS: The Committee's motion was that the resolution be disapproved.

THE FLOOR: Read the resolution again.

DR. DAVIS: I didn't read the actual resolution. I simply gave you a resume of the thing. The resolution was by the delegates from Butler County. It is to have the Advisory Committee to Blue Cross to approach the Blue Cross Hospital Plan and similar hospital plans, urging them to make payments for the use of physical facilities in physicians' offices.

The Committee moved that this resolution be disapproved.

DR. MILLER: May I add one thing more?

If we can properly negotiate with Blue Cross, we have some chance with the commercial insurance companies who also say that no patients can be cared for unless they are hospitalized, and that means many patients are in the hospital twenty-four hours to have a simple fracture reduced that can be taken care of at the office and be sent home. That's the kind of thing we are trying to break up.

The other thing Blue Cross throws to me is that they can pay only a licensed hospital. We don't have a licensed hospital because we can't handle it in our community.

We may have to change that charter. All we are asking is whether the physicians of Kentucky as a whole think it is right for me to be paid for cleaning up my office, Dr. GuDEX, or anybody else in Kentucky, when they will pay the maximum fee to a hospital for cleaning up their work.

SPEAKER HOUSTON: I have a motion and a second. Are you ready for the question?

THE FLOOR: We don't understand the motion.

SPEAKER HOUSTON: There is a resolution presented to the House of Delegates by Dr. Miller requesting that the Advisory Committee of Blue Cross be approached, and other similar hospital plans, urging them to make payment for the use of physical facilities at physicians' offices.

Your Reference Committee for reasons known to itself asks that you disapprove this request at this time. That is the motion, that you will disapprove Dr. Miller's resolution.

A VOICE: Is the motion in order?

SPEAKER HOUSTON: The motion is in order. Any discussion?

THE FLOOR: The question.

DR. SARGENT: I'm Dr. Sargent from Ballard. I'd like to move, if I may—

SPEAKER HOUSTON: You can't do it.

DR. SARGENT: I would like to urge the doctors to approve Dr. Miller's resolution and turn down this one.

DR. MILLER: Dr. Sargent, all you have to do is vote "no" and they will turn down what they approved.

SPEAKER HOUSTON: All those in favor of Dr. Davis' motion to disapprove Dr. D. G. Miller's request will vote "yes." All in favor of Dr. Miller's resolution will vote "no."

(Dr. Davis' motion was put to vote and defeated.)

SPEAKER HOUSTON: So ordered.

Dr. Davis: I move the adoption of this report as amended.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

SPEAKER HOUSTON: Reference Committee Number 6 had to do with Credentials, and I judge there is no report from that Committee.

We are now through with the work of the Reference Committees and I wish to thank these men for the heavy work and load that they carried yesterday. It is certainly of service to the Association.

We have in our midst Dr. Ernest E. Howard, Assistant Secretary of A.M.A. I would like to recognize him at this time. Will you please stand?

(The Assembly arose and applauded.)

SPEAKER HOUSTON: Gentlemen, we now come to the election of our officers. We have to elect a president-elect, three vice-presidents, one from eastern, western, and central Kentucky, a delegate to the A.M.A., and an alternate delegate to the A.M.A., and Orator in Surgery and an Orator in Medicine and one Councilor in the Tenth District.

The Chair will now receive the nominations of the Nominating Committee for president-elect of our Association.

DR. TROUTMAN: Mr. Speaker, Members of the House of Delegates. Your Nominating Committee has placed in nomination the name of Dr. J. Duffy Hancock of Louisville for the president-elect.

SPEAKER HOUSTON: I have the nomination of Dr. J. Duffy Hancock from Louisville. Do I have a nomination from the floor?

DR. MILLER: I move that nominations cease and that the Secretary cast one ballot for the house.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON. So ordered. Dr. Duffy Hancock will be our president-elect for the next year.

We now are to the election of the vice-president from eastern Kentucky.

DR. TROUTMAN: We give you the name of Dr. Charles B. Johnson of Russell, Kentucky.

SPEAKER HOUSTON: I have the name of Dr. Charles B. Johnson. Do I have a nomination from the floor?

DR. SCOTT: I move that nominations be closed and that the Secretary be instructed to cast the ballot of the House.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

We are now ready for the election of the vice-president from central Kentucky.

DR. TROUTMAN: Your Nominating Committee nominates Dr. W. O. Johnson of Louisville for vice-president from central Kentucky.

SPEAKER HOUSTON: I have the name of

Dr. W. O. Johnson of Louisville for vice-president from central Kentucky. Do I have a nomination from the floor?

(A motion was made that nominations be closed and that the secretary be instructed to cast the ballot for the House. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

We are ready now for the election of the vice-president from Western Kentucky.

DR. TROUTMAN: Your Nominating Committee nominates Dr. G. Y. Graves of Bowling Green for vice-president from Western Kentucky.

SPEAKER HOUSTON: I have the name of Dr. G. Y. Graves of Bowling Green for vice-president from Western Kentucky. Do I have a nomination from the floor?

(A motion was made that nominations be closed and that the secretary be instructed to cast the ballot for the House. The motion was regularly seconded, was put to vote, and carried.)

SPEAKER HOUSTON: So ordered.

We will now have the election of the Delegate to the American Medical Association. Dr. Troutman, will you make the nomination?

DR. TROUTMAN: There was certainly a little misunderstanding about this, I might say. This morning it was published in the paper the names of these two men and some of the doctors have thought that we had two delegates to elect and that theirs were the names to be presented. So we again remind you that we only have one delegate to the A.M.A. that is to be elected tonight. There is a carry-over delegate who is the second delegate from this State and we are offering you two names for this nomination. They are Doctors Clark Bailey of Harlan and R. O. Joplin of Louisville.

SPEAKER HOUSTON: We have the names of Dr. Clark Bailey and Dr. R. O. Joplin of Louisville. Are there other nominations from the floor?

(A motion was made that nominations cease, which motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: We will now spread the ballots and vote for either Dr. Clark Bailey of Harlan or Dr. R. O. Joplin of Louisville.

(The tellers spread the ballots.)

SPEAKER HOUSTON: As soon as the ballots are in we will have another nomination while we are counting those.

DR. TROUTMAN: We again offer you two candidates for the Alternate Delegate to the A.M.A. Dr. C. C. Howard of Glasgow and Dr. Thomas V. Gudex of Louisville.

SPEAKER HOUSTON: The chair has two

nominations, Dr. C. C. Howard of Glasgow and Dr. T. V. Gudex of Louisville as Alternate Delegates to A.M.A. Do I have nominations from the floor?

(The motion was made that nominations be closed, which nomination was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

We will now have a new group of tellers, if they will please serve.

(Tellers were appointed.)

SPEAKER HOUSTON: The Chair will now receive nominations for the Orator in Surgery. Dr. Troutman.

DR. TROUTMAN: We are presenting one name, that of Dr. Clifford C. Scott of Lexington, and I am reminded by Dr. John Scott to remind the delegates that they are no kin.

(Laughter.)

SPEAKER HOUSTON: We have the name of Dr. Clifford C. Scott of Lexington. Do I have a nomination from the floor?

DR. ATKINSON: In view of the explanation, I will move that the nominations cease, and that the Secretary be instructed to cast the ballot for the House.

(The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

DR. TROUTMAN: For the Orator in Medicine, we give you the name of Dr. Paul Simpson of Covington.

SPEAKER HOUSTON: We have the name of Dr. Paul Simpson of Covington. Do I have a nomination from the floor?

(A motion was made that nominations cease and that the Secretary be directed to cast the ballot of the House. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

Who is the Chairman of the Delegation of the Tenth District? Will you please give the nomination of the Councilor for the Tenth District?

DR. RICHARD ELLIOTT: We place in nomination from the Tenth District the name of Dr. J. Farra Van Meter.

(A motion was made that nominations cease. The motion was regularly seconded, was put to vote and carried.)

SPEAKER HOUSTON: So ordered.

Are there any announcements or other business while the ballots are being counted in the two elections?

A VOICE: I suggest that while we are waiting, the President-elect come forward.

SPEAKER HOUSTON: Is Dr. J. Duffy Hancock in the room?

(Applause.)

SPEAKER HOUSTON: May I ask that Dr. Bailey and Dr. Barr escort Dr. Hancock to the platform?

(Dr. J. Duffy Hancock was escorted to the platform. The Assembly arose and applauded.)

SPEAKER HOUSTON: May I present Dr. J. Duffy Hancock, President-elect of our Association. Dr. Hancock.

(Applause.)

DR. HANCOCK: Mr. Speaker, members of the House: I know it is late. I will just delay you a few minutes while they count the ballots. I am afraid I can't express adequately my appreciation for the honor you have given me. According to my standards, this honor is the greatest one that can come to a Kentucky physician. It implies not only a recognition of a reasonable degree of professional ability, but I think even further it implies confidence in the recipient's loyalty and support to his profession.

My family background has been medical in that my father and two of my uncles each practiced over fifty years. My social background is pretty much the same, since most of my friends are physicians. To be so honored by those of us who know me well, it is a source of great personal satisfaction and a stimulus to follow directly in the footsteps of the distinguished and illustrious predecessors whom I will follow.

Thank you.

(Applause.)

SPEAKER HOUSTON: The Chair wishes to announce that in the vote between Dr. Clark Bailey and Dr. R. O. Joplin for Delegate to the American Medical Association, there were eighty-eight ballots cast. Dr. Clark Bailey, 59; Dr. R. O. Joplin, 29. Clark Bailey will be our Delegate to the American Medical Association.

I think some in the room might not know the new Vice-Presidents. I don't know if they are here or not. I'd like to ask them to stand if they are.

Dr. Charles B. Johnson of Russell.

(Applause.)

SPEAKER HOUSTON: Dr. W. O. Johnson of Louisville. Dr. G. Y. Graves of Bowling Green.

I don't believe they are here.

SPEAKER HOUSTON: In the voting for Alternate Delegate to the American Medical Association, there were 86 ballots cast. Dr. C. C. Howard, 24; Dr. T. V. Gudex, 62. Dr. Gudex will be our Alternate Delegate to the American Medical Association.

Is there any further business that should come before this House?

(No response.)

SPEAKER HOUSTON: If not, I will accept a motion for adjournment.

(A motion was so made, was regularly seconded, was put to vote and carried. Whereupon, the meeting adjourned at 11:15 p.m.)

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First District J. Vernon Pace, 109-10 Citizens Bank Bldg., Paducah	1953
Second District Walter L. O'Nan, 237 Second St., Henderson	1953
Third District Delmas M. Clardy, Hopkinsville	1953
Fourth District J. I. Greenwell, New Haven	1953
Fifth District Richard R. Slucher, Buechel	1954
Sixth District L. O. Toomey, Bowling Green	1954
Seventh District Branham B. Baughman, Frankfort	1953
Eighth District Edward B. Mersch, 92 Arcadia, Covington	1954
Ninth District J. R. Cummings, Flemingsburg	1953
Tenth District J. Farra Van Meter, 183 N. Upper Street, Lexington	1952
Eleventh District Hugh Mahaffey, Richmond	1953
Twelfth District Carl Norfleet, Somerset	1953
Thirteenth District Clyde C. Sparks, Mayo Arcade, Ashland, Chairman	1953
Fourteenth District Paul B. Hall, Paintsville	1953
Fifteenth District Edward Wilson, Pineville	1954

EDITORIALS

AMERICA'S ACHILLES HEEL

"Every military man knows that the first thing he must do after winning a battle is to dig in. For the counterattack is on its way—sooner or later." This statement by R. Haynes Barr, M. D., Kentucky State Medical Association president in an address before the Campbell-Kenton County Medical Society, clearly applies to the medical profession in its war against socialism and its defense of free American institutions.

The greatest danger confronting the American people today, including the medical profession, is complacency. It must be guarded against with every instrument at our command.

It would be the greatest folly to assume that the November 4 election ended Medicine's problems. This is especially true since both Mr. Stevenson and Mr. Eisenhower publicly announced their opposition to socialized medicine. Recognizing this, many physicians and other opponents of statism felt they could vote for Mr. Stevenson and did. This fact, plus the extremely complex nature of every individual's voting pattern, emphasizes that the election results cannot be construed as the end of the war against socialism.

Members of both major parties will be happy to see Oscar Ewing, Michael Davis, and men of their ilk leave the seats of influence which they have so long prostituted. It is no small gain that men of this type will no longer be able to misuse their power. Their efforts will undoubtedly be handicapped in the future. This does not mean, however, that they will quit.

No surrender flag has been raised by

the statist. While they live and can command any audience, they will continue to fight. So long as defects—no matter how insignificant—exist in the product of the American way, the socialist will use them to confuse the people. And where no defects exist, he will invent them.

Already the Committee for the Nation's Health has begun its post-election campaign. It has issued an attack on the medical profession's "opposition to group health insurance plans." It is clear that the future pattern will be a steady drum-fire of propaganda aimed at discrediting organized medicine. It well behooves the profession, therefore, to dig in. Dig in by strengthening and expanding its efforts to meet remaining health problems through voluntary means on the local and state level.

George F. Lull, M. D., well described America's gains when he said in a recent A.M.A. *Secretary's Letter*: "Doctors will no longer have to dance to the tune of the Ewing pipers, but can devote their full time and energy to a sound, constructive, and unselfish program of better medical care for all the people—a program completely divorced from politics."

This re-emphasizes that now, as never before in recent times, we have an opportunity to "accentuate the positive." We cannot, however, relax the efforts we have begun so well.

The "Achilles heel" of democracy is complacency. Our way of life can only be defended through continuing voluntary co-operation and vigilance. Eternal vigilance.

WHAT IS IT?

You and I must know the answer!

We, as physicians, should never be placed in the embarrassing position of having to ask, "What is it?" with reference to so important a proposition as the community rural health council.

The people's recent nation-wide man-

date, endorsing medicine's contention that voluntary co-operation is the key to health progress, increases the responsibility which you and I have, as individuals, to help guarantee that the American way will succeed.

Because the community rural health

council is an important part of the American voluntary way, every physician should know "What it is." In case you do not, we have prepared a brief description.

You are urged to familiarize yourself with it, because the odds are great that your community leaders will ask for your help during the coming months.

A local rural health council is an organization in which all groups and individuals can study and plan together to improve the health of the community. It can serve as an outlet for lay and professional information. It facilitates joint action when desirable and reduces unnecessary duplication in a manner which is thoroughly in keeping with the highest traditions of true democracy. Its key words are "voluntary" and "co-operation."

It has been emphasized repeatedly in the rural health council movement that rural health and rural medical care are not one and the same thing. Medical care is a purchasable service, while health is a non-purchasable product that can come only through the exercise of community co-operation and individual responsibility.

While medical care problems have not been overlooked, the rural health council movement has chiefly served to alert people to the fact that their own health can best be raised only through the application of knowledge and common sense to widely divergent elements in their environments.

Farm people are being conditioned everywhere to recognize that their good health depends on such factors as personal hygiene, sanitation, health education, nutrition, control of communicable disease, animal health, farm hazards, as well as upon medical care.

Encouragement has been given to the development of voluntary prepaid medical

and hospital-care plans. The people have been made more fully aware that to keep a doctor, they must use him.

Highly significant in the rural health council program has been the insistence that its success depends on voluntary co-operation at the local level. This places a heavy responsibility on individual physicians and individual laymen—a responsibility which is most compatible with the best in grass-roots good citizenship.

Great strides have already been made in strengthening mutual understanding between the medical profession and residents of rural areas through the national work of the A.M.A. Council on Rural Health and through the rural health committees of various state and county medical societies. Co-ordination and co-operation between physicians and farmers have been developed. Each has learned better how to work with the other THROUGH working with the other. The results have been good for both.

The responsibility for furthering this good work in our own Kentucky communities falls most heavily upon us who are physicians. The people look to us for guidance and advice. Without our counsel their best intentions may lead them astray, perhaps to tragedy. With our help, they can learn and progress. The product will be a better community for us as physicians and for all of us as citizens.

You may need help in fulfilling your obligation. Certainly you will want additional information. If you contact our rural health committee through the Kentucky State Medical Association headquarters office, we can provide you with prompt and effective assistance.

WALTER L. O'NAN, Chairman
Committee on Rural Health

THE HOSPITAL PROGRAM OF THE UMWA WELFARE FUND

The United Mine Workers of America through its welfare and retirement fund has had a profound influence on the practice of medicine in the coal mining area of Kentucky. There is presently contemplated a hospital building program which will greatly increase this influence. The

Memorial Hospital Association, which is to be financed by loans from the U.M.W.A. Welfare and Retirement Fund and is controlled by it, contemplates constructing, equipping, and operating hospitals at or near Harlan, Pikeville, Hazard, Middles-

(Continued on p. 622)

President's Page

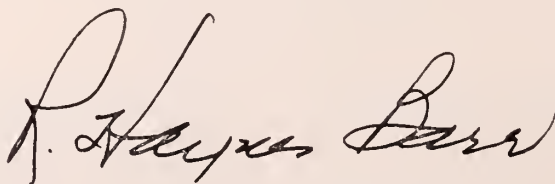
Last year for the first time the Kentucky State Medical Association in co-operation with the School of Medicine, University of Louisville, initiated the "Telephone Post-Graduate Course." After the programs were worked out and definite dates established by Dr. Robert Lich's committee on Medical Education, various county societies applied for participation.

The headquarters staff then arranged with the telephone company to have a clear line installed into the county society meeting place. Several days in advance of each program copies of the text material were mailed in sufficient quantity for each listening physician to better familiarize himself with the subject matter. The cost of the program to the individual physician depends on the size of the county medical society and even in the smallest group does not approximate more than a house call.

As a result of these programs' popularity, your committee has this year planned four seminars which will be presented on the evenings of January 27, February 24, March 31, and April 28. The topics for the programs will be published in the Journal. It is also anticipated that eight or ten lantern slides will be furnished in advance to illustrate each program. Last year 28 county societies availed themselves of this excellent post-graduate instruction, constituting the largest medical audience ever assembled in Kentucky.

While this post-graduate feature is well adapted to county societies of any size, it should be especially attractive to the smaller societies because of its economy as contrasted with the expense of securing prominent out-of-town speakers or with individual doctors traveling great distances to meetings. It is hoped that many additional county societies will take advantage of this opportunity, a real bargain in bringing to your members the latest developments in various medical fields.

As the holiday season approaches, I wish to express to every member of the Kentucky State Medical Association my sincere wish for a very Merry Christmas and a happy and satisfying New Year.

A handwritten signature in cursive script, reading "R. Hayes Barr". The signature is written in dark ink and is positioned above the printed name of the President.

PRESIDENT

ORGANIZATION SECTION

First Broadcast Jan. 27 Features

Abdominal Emergencies

"Abdominal Emergencies" is the subject of the first of the 1953 series of four telephone seminars and will be broadcast Thursday, January 27, at 7:30 p.m. over a state-wide telephone hook-up, according to Robert Lich, Jr., M. D., Louisville, chairman of the Committee on Medical Education.

Dr. Lich said this year's series will again be sponsored by the Kentucky State Medical Association in co-operation with the University of Louisville School of Medicine. The association will take care of the business and technical part of the series, and the medical school will prepare the manual and slides. The medical education committee and the school co-operate in arranging for the program material and its presentation.

Participants in the first panel will be William Blodgett, M. D., Rudolph Noer, M. D., and Silas Starr, M. D., with Dr. Lich as moderator. All are members of the medical school faculty.

The subject of acute abdominal disorders is to be discussed from its various surgical and medical aspects. It is the purpose of this symposium to review briefly the salient diagnostic and therapeutic features of the common and unusual abdominal disturbances of immediate and grave consequence.

A new feature of the coming series will see the subscribing county medical societies' members viewing ten especially prepared slides for each broadcast flashed on the screen and keyed to the presentation of the material by the panel.

The Committee on Medical Education has urged that the county medical societies prepare for a discussion of the topic of the panel at the conclusion of each program. Representatives of the subscribing county groups will be urged to attend one of the "dry run" or practice sessions of the panel as it prepares for the broadcast.

Twenty-eight county societies signed up for the first series in 1952. Because of the economy of the program and the high caliber of the material that was demonstrated in the first series, Dr. Lich said, the committee expects a much larger number of counties to participate in the 1953 group of programs.



John Guy Miller

John Guy Miller Appointed KSMA Field Secretary

John Guy Miller joined the staff of the Kentucky State Medical Association as its new field secretary November 1. He comes from St. Louis, where he was executive secretary of the St. Louis Medical Society.

Medical organization work has occupied Mr. Miller's time for the past five years. Prior to his association with the St. Louis Medical Society, he acted as field secretary with the Michigan State Medical Society.

A graduate of the University of Missouri and a former newspaper man, he served four years in the U. S. Marine Corps during World War II, attaining the rank of captain.

In addition to his newspaper and medical organization work, Mr. Miller served as field director for one of the largest public relations counseling firms in the Mid-West.

Dr. Hancock to Go to Fund Kick-Off

J. Duffy Hancock, M. D., Louisville, president-elect of the Kentucky State Medical Association and chairman of the Committee for Contributions to American Medical Education

Foundation, will attend the kick-off of the 1953 fund-raising drive on Sunday, January 25, at the Sheraton Hotel, Chicago. Representatives from every state will exchange experiences and ideas on local fund-raising to aid in the medical profession's annual drive for voluntary support for medical schools.

Third County Officers Conference Set for March 5

Plans for the Third Annual County Society Officers Conference to be held at the Brown Hotel, Louisville, Thursday, March 5, 1953, were approved by the executive committee of the Council at its November 13 meeting. Clyde C. Sparks, M. D., Ashland, chairman of the Council, announced.

Following the 1952 conference, a questionnaire was sent to those who attended with the request that the attendants list topics they would like most to have discussed at the 1953 conference. According to Dr. Sparks, the response was most gratifying, and this year's program will be built around the subjects that were suggested most.

Topics prominently mentioned by last year's conference-goers were fees, the doctor's role in community relations, press-physician relations, rural health, and abuses of voluntary health plans. Nationally known experts in these fields will be engaged to discuss these topics at the conference.

All members of the Kentucky State Medical Association are invited to attend what R. Haynes Barr, M. D., Owensboro, president, described as "one of the best and most important functions of the association." All county medical society officers and chairmen of the public relations, rural health, and legislative committees, along with chairmen of all state association committees are especially urged to attend the March 5 meeting.

Watch for more details of the coming day-long conference in the January issue of the Journal.

State Rural Health Conference Announced March 11, 12

The Second Annual Kentucky Rural Health Conference will be held in Louisville, March 11 and 12, 1953, according to an announcement made by Walter L. O'Nan, M. D., chairman of the Kentucky Rural Health Council.

The selection of the time and place for the 1953 state rural health conference was made at

a meeting of the Kentucky Rural Health Council in Louisville, Wednesday, November 5. The council consists of representatives from 13 state-wide organizations which are interested in the improvement of rural health in Kentucky.

Dr. O'Nan, who is also chairman of the Kentucky State Medical Association's Advisory Committee on Rural Health, stated that all persons interested in rural health in the state will be invited to attend the March conference.

The Rural Health Council meeting re-elected Dr. O'Nan as chairman. Other officers to serve during the coming year are Miss Myrtle Weldon, state leader of Kentucky Home Demonstration Agents, vice-chairman; Joseph P. Sanford, secretary-treasurer; and John Guy Miller, field director. The latter two are from the K.S.M.A. headquarters staff.

Attention of the conferees was called to the Eighth National Rural Health Conference to be held at the Hotel Roanoke, Roanoke, Virginia, February 27 and 28, 1953. This conference, which is sponsored by the American Medical Association, will be preceded on February 26 by an informal session for doctors of medicine.

Joint Hospital Commission Starts New Accrediting Program

The new Joint Commission on Accreditation of Hospitals is scheduled to officially take over the hospital standardization program at a meeting in Chicago on Saturday, December 6, according to an announcement by George F. Lull, M. D., Secretary and General Manager of the American Medical Association.

Gunnar Gundersen, M. D., La Crosse, Wisconsin, and a member of the A.M.A. Board of Trustees, is serving as the first chairman of the commission, which will handle the program that has been the responsibility of the Board of Regents of the American College of Surgeons prior to this time. Permanent offices will be maintained at 660 Rush Street, Chicago, with Edwin L. Crosby, M. D., former director of Johns Hopkins Hospital, Baltimore, as the executive director.

The Joint Commission on Accreditation of Hospitals is made up of representatives from the American Medical Association, the American College of Physicians, the American College of Surgeons, the American Hospital Association and the Canadian Medical Association.



Physician members and guests at speaker's table during November 5 dinner meeting of the Campbell-Kenton Medical Society at Covington are, left to right: George Riley, vice-president and member of K.S.M.A. rural health committee; Norman Adair, secretary and member of K.S.M.A. legislative committee; Richard Rust, delegate and member of K.S.M.A. advisory committee to the editors; W. Vinson Pierce, delegate and chairman of K.S.M.A. education campaign committee, who introduced the speaker; R. Haynes Barr, K.S.M.A. president and guest speaker; C. Walker Air, society president, who presided; Lewis Hafer, honored guest, who received 50-year scroll; James A. Ryan, life-long friend of Dr. Hafer, who presented scroll; and Edward Mersch, K.S.M.A. councilor for the 8th district.

Dr. Rowntree to Lead Conference on Industrial Health

Gradie R. Rowntree, M. D., Louisville, chairman of the Advisory Committee on Industrial Medicine and Surgery of the Kentucky State Medical Association, will preside at the Joint Conference of the American Medical Association Council on Industrial Health and state society representatives January 20 in Chicago.

The Conference is in conjunction with the 13th annual Congress on Industrial Health, sponsored by the A.M.A. Council, at the Drake Hotel, Chicago, on January 21 and 22, and attended by workers, industrial leaders, and medical men interested in improving health services of the nation's working force.

A summary based on the reports of states representatives will be presented at the Conference on their year's activities, and conferees will engage in round table discussion on the three main areas of industrial health: education, service, and research.

New KSMA Members Welcomed

The Association is pleased to welcome the following new members:

Hardin—Oris Aaron, Elizabethtown.

Monroe—William R. Bushong, Tompkinsville.

Results of Second Diabetes Drive May Exceed 1951

The second annual Diabetes Detection Week in Kentucky, November 16-22, came to a close with what Carlisle Morse, M. D., chairman of the Kentucky State Medical Association Diabetes Committee described as even finer results than those obtained in the 1951 campaign.

The Diabetes Detection Drive, which is sponsored by the Kentucky State Medical Association in co-operation with the American Diabetes Association, is devoted to an effort to get every person to have a urine-sugar test.

The full implementation of the program was carried out by diabetes committees named by the county medical societies all over the state. These committees set up the procedures for giving the tests and arranged for full publicity of the drives in their respective counties.

"It has been gratifying to see the increased interest on the part of K.S.M.A. members and their willingness to participate in the program," Dr. Morse said. "This is especially good because the diabetes detection program is one for which the physicians have assumed full responsibility. That this responsibility is being readily accepted is shown by the fact that over 80 county medical societies in the state partici-

pated in the 1952 campaign, an increase of 25 per cent over last year.

"Fuller publicity coverage by means of the press, radio and television have also been important in the success of the 1952 drive," Dr. Morse continued. "While complete reports are not yet in on any phase of the diabetes detection campaign, it is clear that many columns of newspaper space and many hours of radio and television time have been devoted to informing the public of the association's diabetes program.

"Typical was the work of the state committee in arranging for over three hours of radio and television time on Louisville stations. This included two television programs of 15 and 30 minutes, respectively, and eight radio programs in addition to numerous spot announcements. The state committee issued news releases throughout the state during the two weeks preceding the campaign. These were widely used by the Kentucky daily and weekly press and the local radio stations."

Eleven Kentucky Men Appear on Southern Medical Program

Eleven Kentucky physicians appeared before the Southern Medical Association's sessions at Miami, November 10 to 13, as essayists, scientific exhibitors, discussors, and panel members.

Speakers or exhibitors and their subjects were as follows:

K. Armand Fischer, M. D., Louisville: "Indications for Bone Grafting in the Primary Treatment of Fractures."

Oscar J. Hayes, M. D., Louisville: "Microscopic Changes of the Cervix in Pregnancy."

W. O. Johnson, M. D., Louisville: "Evaluation of Thyroid Therapy on Ovarian Function: Clinical and Laboratory Studies."

Arthur H. Keeney, M. D., Louisville: "Changing Concepts in the Differential Diagnosis and Complications of Orbital Inflammation."

William K. Massie, M. D., Lexington: "Functional Fixation of Fractures of the Lower Extremities."

Everett L. Pirkey, M. D. Louisville: "Changes in the Gastro-Intestinal Tract Associated with Aging."

George B. Sanders, M. D., Louisville: "Bilateral Mastectomy for Breast Cancer." (Lantern slides and scientific exhibit.)

D. G. Miller, Jr., M. D., Morgantown: Scientific exhibit: Rural General Practice without a Hospital.

John S. Harter, M. D., Louisville. Discussor on "Ten Years Surgical Experience of Cancer of the Lung."

Robert Lich, Jr., M. D., Louisville. Discussor on "Modified Suprapubic Prostatectomy."

Everett L. Pirkey, M. D., Louisville. Discussor on "Roentgenographic Variations of the Normal Stomach and Duodenum."

D. G. Miller, Jr., M. D., Morgantown. Panel on General Practice.

Ephraim Roseman, M. D., Louisville, Presidential address before Electroencephalographic Society meeting jointly with the Section on Neurology and Psychiatry of the S.M.A.

Fifty-eight Ky. M. D.'s Attend SMA at Miami, November 10-13

Fifty-eight Kentucky physicians were among the 2,100 who attended the annual session of the Southern Medical Association November 10 to 13, at Miami, it was reported by C. P. Lorz, secretary-manager of the association.

A. Clayton McCarty, M. D., Louisville, is the new Councilor from Kentucky to S.M.A., succeeding James A. Ryan, M. D., Covington.

Physicians who attended the Miami meeting were: Lyman S. Hall and Michael M. Hall, Campbellsville; Norman Adair, George N. Burger, Elmer E. Devillez, Clifford N. Heisel, W. Vinson Pierce, and Arthur J. Schwertman, Covington; James C. Hancock and Russell Rudd, Fulton; William H. Bryant, Glasgow; John T. Walsh, La Grange; and William K. Massie, Jr. and John B. Floyd, Jr., Lexington.

S. Pearson Auerback, Malcolm L. Barnes, Henry S. Collier, Raymond C. Comstock, Michael R. Cronen, Ralph M. Denham, K. Armand Fischer, E. R. Gernert, Joseph L. Goldstein, John S. Harter, Oscar J. Hayes, W. O. Johnson, W. W. Johnson, Arthur H. Keeney, Nathan Levene, Robert Lich, Jr., James S. Lutz, Paul Mapother, A. Clayton McCarty, Oscar O. Miller, Charles T. Moran, Sam A. Overstreet, Everett L. Pirkey, Ephraim Roseman, James E. Ryan, George B. Sanders, Edwin P. Scott, and Edwin P. Solomon, Louisville.

Leland E. Payton, Lynch; Harry C. Denham, Maysville; James O. Willoughby, Morgantown; A. D. Butterworth, James C. Hart, Conrad H. Jones, and Ora K. Mason, Murray; Thomas J. Crume, Jr., Owensboro; T. J. Marshall, Paducah; Walter R. Byrne, Russellville; F. J. Halcomb, Scottsville; James O. Willoughby, Shepherdsville; M. Carroll Spradlin, Somerset; Ralph L. Gullett, West Liberty; Louis J. Beto, Winchester; and Raymond D. Sanders, Williamsburg.

Five KSMA Members to Consider Medical School Proposal

Five members of Kentucky State Medical Association have been appointed as an advisory committee on medical education by the Legislative Research Commission to consider the proposal of establishing a medical school at the University of Kentucky.

The committee includes R. Haynes Barr, M.D., Owensboro, president of K.S.M.A., Clyde C. Sparks, M.D., Ashland, council chairman, Branham B. Baughman, M.D., Frankfort, J. Vernon Pace, M.D., Paducah, and Edward H. Ray, M.D., Lexington.

According to published accounts, they were named by the L.R.C. to assist the commission in forming its report to the Legislature on the following:

"1. The need for improved medical services in Kentucky.

"2. The scope of a medical education program necessary to meet these needs.

"3. Detailed requirements for establishing a medical school at U. K., including staff, buildings, equipment, library, hospital, and clinical training facilities."

Doctor Draft Law Extension Contemplated

Preparation for extension and amendment of the doctor draft law, which expires June 30, has begun with a conference of Defense Department officials and representatives of other departments and professional associations, according to Frank Wilson, M. D., director of the A.M.A. Washington office.

The specific problems of physician-dentist-veterinarian draft as outlined by a Defense Department spokesman are:

Approaching exhaustion of Medical Priorities I and II will necessitate resort to Priorities III and IV. With insufficient young men in Priority III to meet requirements, unless younger men in IV are made available by law, too many of colonel and major age and experience and not enough for captain and lieutenant commissions will be offered the services. The possibly high percentage of Priority IV men with two or more years active service and the displacing from civilian practice of physicians of 15 to 20 years experience complicate the picture further.

Not until 1958 will the professional manpower shortage be ended by the completion of medical training of deferred non-veterans.

No conclusions were reached at the first meeting or commitments sought for support of the law's extension. Those participating in the discussions were the Defense Department's Armed Forces Medical Policy Council and representatives of the Armed Forces, the department's manpower division, Selective Service, the Rusk committee, and spokesmen for dentists, veterinarians, hospitals, medical schools, and the American Medical Association.

Program for ACS Sectional Meeting Lists Three Ky. Surgeons

Kentucky surgeons who will participate in the scientific program of the sectional meeting of the American College of Surgeons in Cincinnati next January 19 to 21, are Laman A. Gray, M. D., R. Arnold Griswold, M. D., and Charles F. Wood, M. D., all of Louisville.

The meeting will be in the Netherlands Plaza Hotel and is the first of eight scheduled for various parts of North and South America during the coming year. Representation will be from at least seven states and Ontario.

The opening program, a symposium on trauma, will feature Dr. Wood as one of the speakers, his subject being "The Present Status of Intramedullary Nailing." Dr. Griswold will serve as moderator in a panel discussion, January 20, on "Tumors of the Neck," and Dr. Gray, who will be one of three discussors on gynecology, will talk on "Carcinoma of the Cervix." The last day will be devoted to a clinical schedule at Cincinnati's largest hospitals.

School Health Committee Meets for First Time

The Advisory Committee on School Health of the Kentucky State Medical Association held its first meeting November 13, in Louisville, with invited representatives of the state's Department of Education and Department of Health.

Daryl P. Harvey, M. D., Glasgow, chairman, stated the purpose of the meeting as exploratory in nature and the dual function of the committee as research into school health problems and recommendations to the council for action. The need, it was agreed, was for careful selection of activities in which the medical profession can most effectively use its weight to improve school health in Kentucky.

Other committee members present were Carl Grant, M. D., Winchester, Walter L. O'Nan, M. D., Henderson, and Carl Pigman, M. D., Whitesburg. R. Haynes Barr, M. D., presi-

dent, attended the meeting briefly. H. B. Mack, M. D., Pewee Valley, D. G. Miller, M. D., Morgantown, and W. J. Temple, M. D., Covington, were absent.

Guests of the committee were Donald A. Dukelow, M. D., of the A.M.A. Bureau of Health Education, E. B. Whelan, director of health and physical education, Kentucky Department of Education, and Harry K. Dillard, M. D., director of the school health division, Kentucky Department of Health.

Student M. D.'s See Cancer Film

"Breast Cancer—Problems of Its Early Diagnosis," was the title of a film shown at the December 1 meeting of the University of Louisville chapter of the Student American Medical Association at the General Hospital amphitheatre.

According to Peter Overstreet, a senior medical student and president of the local chapter, the organization, now in its second year, has a membership of 200.

Campbell-Kenton Society Honors Dr. Hafer November 6

R. Haynes Barr, M. D., president of the Kentucky State Medical Association, and Lewis C. Hafer, M. D., Hebron, were guests of honor at a dinner meeting of the Campbell-Kenton County Medical Society held in Covington, Thursday, November 6. C. Walker Air, M. D., president of the society, conducted the meeting.

Dr. Hafer received a distinguished service certificate awarded by the Campbell-Kenton Medical Society for his fifty years' contribution to medicine and the community since his graduation from medical school. His life of service was described in a simple ceremony by James A. Ryan, M. D., Covington. A former vice-president and councilor of the Kentucky State Medical Association and past-president of the Campbell-Kenton society, Dr. Hafer's career in pediatrics and his role in establishing the first pediatric department in the Campbell-Kenton area were especially lauded.

Dr. Barr, who was introduced as the principal speaker by W. Vinson Pierce, M. D., Covington, urged the need for full physician participation in community affairs. He cautioned against complacency in the face of socialization threats, citing the efforts of the International Labor Organization to impose socialized medicine upon all of its member nations, including

the United States. "We have closed the door to socialization," he said, "but the windows are still wide open."

The activities of the Kentucky State Medical Association as an instrument of the profession to provide service to both medicine and the public were stressed by Dr. Barr. He praised the work of the numerous committee members and officers whose sacrifice make the K.S.M.A. service program possible.

Eleventh District Dinner Attracts 65 Physicians and Wives

Over 65 physicians and their wives attended a dinner meeting of the Kentucky State Medical Association Eleventh Councilor District at Benault Inn, Richmond, Wednesday, November 19.

The meeting was called by Hugh Mahaffey, M. D., councilor of the Eleventh District, and was presided over by J. Bates Henderson, president of the Madison County Medical Society, which acted as host.

Following the dinner, the ladies withdrew to the home of Mrs. William C. Cloyd, Jr., for a meeting of the Woman's Auxiliary while W. O. Johnson, M. D., Louisville, and Bruce Underwood, M. D., secretary and general manager of the association addressed the physicians. The auxiliary meeting was called by Mrs. Garland H. Clark, Winchester, Woman's Auxiliary councilor; guests of honor were Mrs. D. W. Barrow, Lexington, state president of the Woman's Auxiliary, and Mrs. Clyde C. Sparks, Ashland, state president-elect.

Huff U. of L. Delegate to Chicago for Student AMA Meet

John Huff, a junior student at the University of Louisville School of Medicine, will attend as delegate from the University chapter the 1952 annual session of the Student American Medical Association December 30 and 31, at the Sheraton Hotel, Chicago, it was announced by Peter Overstreet, president of the chapter.

Charles McGaff, the first and only past-president of the local group, will also attend. He is a member of the eight-man executive committee of the national body, having been elected at last year's national meeting to this honor.

The S.A.M.A., now in its second year, will discuss the means of getting the organization better established, increasing its size and strength all over the country. Walter C. Al-

varez, M. D., Chicago, professor emeritus of the Mayo Clinic, will address the assembly December 30, on "The Disappearing Art of Diagnosing with the Eyes and Ears."

Doctors Moore and Grise Elected Officers of 6th District

Carter Moore, M. D., Franklin, was elected president and Richard F. Grise, M. D., Bowling Green, was elected secretary of the Sixth District at a dinner meeting on November 11, L. O. Toomey, M. D., councilor, has announced.

Hugh L. Houston, M. D., Murray, was the principal speaker at the meeting, which was attended by some 35 physicians. Also included on the program was a movie. The program was sponsored by the Kentucky Heart Association.

The Simpson County Medical Society was host for the meeting. Retiring officers of this district are William C. Wells, M. D., Glasgow, president, and William Carson, M. D., Bowling Green, secretary.

Dr. Holloway Wins A.C.S. Award

J. B. Holloway, M. D., of the Lexington Clinic recently received a check for \$100.00 as first prize from the 1952 committee on awards of the Georgia chapter of the American College of Surgeons for his paper on "Sympathectomy."

The Journal is indebted to Francis M. Massie, M. D., Lexington, for submitting this information.

Pertinent Paragraphs

A "first" was achieved by the Knott County Medical Society on November 20, in leading the state's societies in remitting its 1953 officers' list and dues in the Kentucky State Medical Association. M. F. Kelley, M. D., Hindman, is secretary of the society.

Today's Health magazine has become a class text on the college campus. At the University of Illinois, Champaign-Urbana campus, it is read as classroom assignments by more than 1,300 freshman physical education students; a supplementary study sheet on discussion topics is contributed by the A.M.A. Bureau of Health Education.

Meningococcal infections were 18 per cent higher in the disease year ending September 1, than in the previous year, continuing the upward trend since 1948, it was reported by PHS. The agency noted that meningococcal meningitis occurs in cycles with six to 12 years between peaks of incidence.

Indications are that the incidence rate of poliomyelitis for 1952 will be around 35 per 100,000 estimated population, highest since 1916, when it was 42.

The six-year-old federal act requiring registration of lobby-for-pay groups continues in force without change as the result of a Supreme Court ruling October 13, reversing the decision last March of a special tribunal that criminal penalties were unconstitutional by violating guarantees of free speech and petition to Congress. The law remains intact (unless a new case is successfully brought against it), and the earlier ruling is invalidated because it was charged (a) deletions of certain sections nullified the whole act and (b) the court order was entered against Attorney General McGrath after his resignation.

Penalties for violation run as high as \$10,000 in fines and five years in prison. The National Association of Manufacturers, who appealed the case, claimed exemption because its principal activity was not lobbying.

"The Amazing Story," a new pamphlet of the A.M.A., pictorializes through "Mr. and Mrs. Joe Typical and family" the many services that the A.M.A. provides for an average American family.

The Committee on Medical Motion Pictures of the American Medical Association has announced the publication of a new revised film list, which includes 78 medical films not readily available from other sources, George F. Lull, M. D., Secretary and General Manager of the American Medical Association, has stated. A copy of this list may be obtained by writing to the Committee on Medical Motion Pictures, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

The Atlanta Graduate Medical Assembly and Southeastern Section of the American College of Surgeons will meet simultaneously in Atlanta February 23 to 25, 1953, it was announced by Mark S. Dougherty, M. D., Atlanta, chairman of the A.G.M.A. meeting. William G. Hamm, M. D., Atlanta, is chairman of arrangements for the A.C.S. meeting.

THE HOSPITAL PROGRAM OF THE UMWA

(Continued from p. 613)

boro, Whitesburg, and Wheelwright in Kentucky, at Beckley, Logan, and Williamson in West Virginia, and at Wise in Virginia.

In a recent address before the American Public Health Association, Warren F. Draper, M. D., executive medical officer of the U.M.W.A. Welfare and Retirement Fund, makes the following statement:

"Views as to the methods of staffing and operation that will insure the highest type of hospital and medical service possible under the conditions that exist either have been or will be sought from physicians in the areas concerned, from their state and local medical societies, from the Medical Advisory Committee of the Fund, and from other sources from which useful knowledge and experience are obtainable.

Final decision as to the plans to be adopted will be reached only after thorough consideration of all the data and experience that can be gathered."

This expression from the medical director of the fund should be welcomed by the medical profession of Kentucky. A program of this magnitude affects the practice of medicine throughout the state. The K.S.M.A. Advisory Committee to the fund welcomes suggestions from physicians who have given thought to the problem of medical care for the coal miner. The physicians of Kentucky and the U.M.W.A. Welfare and Retirement Fund have a common objective—the best possible medical care. It is both our duty and our privilege to co-operate when our help is asked.

CARL H. FORTUNE, Chairman
Advisory Committee on United
Mine Workers Health and Welfare Fund

News Items

R. Haynes Barr, M. D., Owensboro, president, represented K.S.M.A. at the Indiana State Medical Association's annual dinner in Indianapolis, October 30.

Silas Starr, M. D., clinical professor of obstetrics and gynecology at the University of Louisville School of Medicine, was a consultant on obstetrical hemorrhage in a discussion panel before the Indiana State Medical Association's annual meeting, October 29.

Maurice S. Davis, M. D., Frankfort, has assumed duties as health officer of Franklin county and head of the Franklin County Health Department. Dr. Davis graduated from the University of Louisville School of Medicine and practiced in Lexington. Recently he was engaged in public health work for the City of Nashville, Tennessee.

Chester A. Morris, M. D., Covington, has been named "Man of the Year" by the Pioneer Toastmasters Club of Greater Cincinnati, and received the Merit of Honor of Toastmasters International.

Billy K. Keller, M. D., professor of psychiatry at the University of Louisville School of Medicine, and director of psychiatry, General Hospital, Louisville, addressed the West Virginia

chapter of the American Academy of General Practice November 2, at Charleston, on "Diagnosis and Treatment of Mental Illness."

J. Farra Van Meter, M. D., Lexington, counselor for the Tenth District, was chosen president of the Kentucky division of the American Cancer Society at its annual meeting November 13. Doctor Van Meter succeeds J. Duffy Hancock, M. D., Louisville, president-elect of the Kentucky State Medical Association. C. Melvin Bernhard, M. D., Louisville, was elected vice-president.

L. Douglas Atherton, M. D., has announced his association with **Lytle Atherton, M. D.**, in the practice of urology at 706 Brown Building, Louisville. A graduate of the University of Louisville School of Medicine, Dr. Atherton served his internship at Charity Hospital, New Orleans, then entered the service until 1947 when he went to Nichols Veterans Hospital, leaving there in 1950 to do postgraduate work at Massachusetts General Hospital, Boston.

John J. Casey, M. D., and **R. Burke Casper, M. D.**, have opened an office in Brandenburg for the general practice of medicine. Both are natives of Louisville and 1950 graduates of the University of Louisville School of Medicine. Dr. Casey has been with the army in Panama and Dr. Casper was with the army at Denver.

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UNDER THE SUPERVISION OF THE COUNCIL

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JANUARY TO DECEMBER, INCLUSIVE, 1952

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1952

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1. Moss, Henry N., and D'Alessandro, Domenic R.: The intensity and duration of the effect of Depo-Heparin on venous coagulation time in man. Am. Practitioner & Dig. of Treatment 2:309 (April) 1951

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Season's Greetings

The Journal

OF THE KENTUCKY STATE MEDICAL ASSOCIATION

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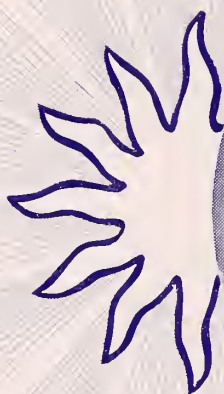
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